

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR DOROTHY M. ADAMS

1. DECEASED'S NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DOROTHY M. ADAMS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10 29 '87</b>		2b. HOUR <b>6:15 P.M.</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DECEMBER 21, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>63</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DEATON MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE <b>611 S. CHARLES STREET 21230</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM E. GLASSER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE MARIE HUEG</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-18-9035</b>		17. INFORMANT <b>NEIL W. ADAMS</b> ADDRESS <b>5555 HUNTING HORN DRIVE ELLCOTT CITY, MD. 21043</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Status Post respiratory arrest and tracheostomy placement**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	19c. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 8</b> , 19 <b>87</b> , to <b>October 29</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>Oct 29</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Fco. Martinez</b>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/30/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Francisco Martinez</b>		22e. ADDRESS <b>611 S. Charles St., BALTIMORE, MD.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>11/2/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>
24. FUNERAL DIRECTOR <b>LEONARD M. &amp; RUSSELL C. WITZKE</b> 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228			25. DATE REC'D BY REGISTRAR <b>NOV 03 1987</b> REGISTRAR'S SIGNATURE <b>Julia Bender-Randall</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Elaine E. Adams</b>			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>10/ 3/ 19 87</b>			2b. HOUR M <input type="checkbox"/> P <input type="checkbox"/>
3. SEX <b>female</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>2</b> YEAR <b>1938</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>48 YRS.</b>	IF UNDER 1 YR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD MONTH <b>10/</b> DAY <b>3/</b> YEAR <b>19 87</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, Md</b>
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Liberty Medical Center</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>	
12b. KIND OF BUSINESS OR INDUSTRY						
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>Md</b>	13b. COUNTY <b>1</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4129 Park Heights Avenue 21215</b>		
14. FATHER'S NAME FIRST <input type="checkbox"/> MIDDLE <input type="checkbox"/> LAST <input type="checkbox"/>			15. MOTHER'S MAIDEN NAME FIRST <input type="checkbox"/> MIDDLE <input type="checkbox"/> LAST <input type="checkbox"/> <b>Anna Cooper</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-74-7754</b>		17. INFORMANT ADDRESS <b>Charles L. Adams, Sr 4129 Park Heights Ave</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>Charles P. Kokes</i>		TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER			DATE SIGNED <b>10/4/87</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Charles P. Kokes, M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/8/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN <b>Randallstown</b> COUNTY <b>Md</b> STATE <b>Md</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H West 4300 Wabash Avenue</b>			25a. DATE REC'D. BY REGISTRAR <b>OCT - 6 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 2 8 3 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN Louise ADAMS			2a. DATE OF DEATH MONTH DAY YEAR 10.26.87		2b. HOUR 4:50 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 7 7 18		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) M.D.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH BALT.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. BALT. GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Nurse &		12b. KIND OF BUSINESS OR INDUSTRY Teacher City
13a. STATE MD		13b. COUNTY BALT.	13c. CITY OR TOWN BALT.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FRITZoff --- DORSCH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN ANDERSON		13e. STREET ADDRESS / ZIP CODE Apt 202 schools 436 HILLVIEW DR 21090	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213301460		17. INFORMANT H. Carl Adams	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LUNG CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cirrhosis, LIVER FAILURE</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10.21.87, to 10.26.87, that (I) (we) lost saw the deceased alive on 10.26.87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Marian Fong, MD.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10.26.87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIAN FONG M.D.		22e. ADDRESS S. BALT. GEN. HOSP.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/29/87	23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto. Md.
24. FUNERAL DIRECTOR NAME McCully Funeral Home Balto., Md. 21225		24b. ADDRESS 237 E. Patapsco Ave.,		25a. DATE REC'D. BY REGISTRAR OCT 30 1987	
				25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 17, Film G632/10-8-87 sb

FOR  
STATE per funeral home  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Robert</b> <b>Nathaniel</b> <b>Adams</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>2</b> YEAR <b>87</b>		2b. HOUR <b>9:10 a.m.</b>
3. SEX <b>M</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>10</b> DAY <b>29</b> YEAR <b>17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> <b>city</b> <b>MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md</b>			13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>T.</b> LAST <b>Adams</b>			15. MOTHER'S MAIDEN NAME FIRST <b>—</b> MIDDLE <b>—</b> LAST <b>—</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>240-20-5362</b>		17. INFORMANT <b>Charles Adams</b> ADDRESS <b>1619 Mont</b> <b>MONTPELIER ST.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>refractory acute nonlymphocytic leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>—</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M.</b> <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <b>W</b> (this hospital) attended the deceased from <b>Oct 2</b> , 19 <b>87</b> , to <b>Oct 2</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>Oct 2</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Brenda W. Cooper, M.D.</b>		DEGREE <b>—</b>		22c. DATE SIGNED <b>10/2/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Brenda W. Cooper, M.D.</b>		22e. ADDRESS <b>University of MD Cancer Ctr. Balt, MD 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10/8/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus</b> <b>—</b> <b>—</b> <b>Md</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H West</b> ADDRESS <b>4300 Wabash Avenue</b>			25a. DATE REC'D. BY REGISTRAR <b>OCT - 6 1987</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		2b. MONTH	2c. DAY	2d. YEAR	2e. HOUR
SYLVIA				ADAMS	10 27 1987					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2f. DATE PRONOUNCED DEAD	2g. MONTH	2h. DAY	2i. YEAR	2j. HOUR
Female	Black	1 1 45	42 YRS.			10 27 1987				7:15 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md	USA				Baltimore City MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore	Maryland General Hospital									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4719 Delaware Ave		21215			
Md.		Baltimore								
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
John Adams				Ivory Love						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No		214-62-8196		Robert Adams		1215 Slater Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE		TITLE (SPECIFY) Deputy Chief				DATE SIGNED 10-28-87				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS								
Ann M. Dixon, M.D.		111 Penn St., Balto., MD				21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		11/2/87		Mt. Zion Cem.		Landsdown, Md.				
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm C March F/H West				4300 Wabash Ave.		NOV 02 1987		[Signature]		

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MADE IN KENYA

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2a DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR 10/ 2/ 19 87 2b HOUR M

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William J. Adams

3 SEX MALE 4 RACE BLACK 5 DATE OF BIRTH MONTH DAY YEAR 2 6 28 6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS. 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC 7b CITIZEN OF WHAT COUNTRY? USA 8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.

10 CITY OR TOWN OF DEATH Baltimore 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 801 E. 43rd Street 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED 12b KIND OF BUSINESS OR INDUSTRY BETH-STEEL

13a STATE MD 13b COUNTY BALTIMORE 13c CITY OR TOWN BALTIMORE 13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS 801 E 43rd STREET 21212

14 FATHER'S NAME FIRST MIDDLE LAST TSACIC ADAMS 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAREY

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) 16b SOCIAL SECURITY NO. 240-44-2623 17 INFORMANT ADDRESS SEDONIA ADAMS 801 E. 43rd STREET

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Fatty Change of Liver  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: Chronic Alcoholism  
(b) DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES ☒ NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles P. Kokes, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10/3/87

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b DATE 10/7/87 23c NAME OF CEMETERY OR CREMATORY KING MEM. PK. CEM. 23d LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN MD

24 FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC. ADDRESS 1101 E. NORTH AVE. 25a DATE REC'D BY REGISTRAR OCT 05 1987 25b REGISTRAR'S SIGNATURE Julia Davidson-Landace

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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25M

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DHMH - 17  
(VR A15 ME (5))



085032 OCT-58



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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
GENEVA F.		ADDISON		10 05 87		3 <sup>02</sup> A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		White		MONTH DAY YEAR 02 24 24		63 YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		U.S.A.				BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Good Samaritan		Homemaker					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
13a. STATE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5802 A Edgepark Rd. 21239			
13b. COUNTY				13c. CITY OR TOWN					
Maryland				Baltimore					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
Louis Fitzwater				Not Known					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		234-42-8225		Mr. Joseph T. Addison		Same as #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK A1 WORK A2		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <del>if</del> (this hospital) attended the deceased from <u>7/21</u> , 19 <u>87</u> , to <u>10/05</u> , 19 <u>87</u> , that <del>we</del> (we) last saw the deceased alive on <u>10/05</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Alison Williams</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALISON WILLIAMS				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Cremation		10-7-87		Westview		Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR (15) REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc. Baltimore, Maryland						OCT 7 1987 <u>John Decker Ruck</u>			

BP



070083 OCT 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 8 3 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Mary Addison								10-20		19		87				M					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR					
female	black	09 30 1925		62 YRS.						10-22-		19		87		5:35 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
N.C.		U S A				Baltimore City MD.															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		400 Eadsdale Eadsdale Rd						Disabled													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		400 Eadsdale Road Apt B 21229													
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																	
FIRST MIDDLE LAST				FIRST MIDDLE LAST																	
Willie Bland				Caroline Streat																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS									
No				212-26-6310				Michael Addison				4404 Pen Lucy Road									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b) DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
Diabetes mellitus																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?									
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
				P.M. 19																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION													
								CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE																TITLE (SPECIFY)		DATE SIGNED			
Charles P. Kokes, M.D.																Assistant		10-23-87			
EXAMINER'S NAME (TYPE OR PRINT)																ADDRESS					
Charles P. Kokes, M.D.																111 Penn Street, Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY		STATE					
Burial				10/27/87		Md Nat Memorial Park				Laurel						Md					
24. FUNERAL DIRECTOR NAME										ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H West										4300 Wabash Avenue				OCT 27 1987				Julia Farnham-Rudolph			

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LIBRARY NOTICES

LIBRARY NOTICES

OCT 21 1981

067958 OCT-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

RUGGIERO

ALBERGO

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
OCTOBER 5, 1987 9:30 P.M.

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
11-15-97

6. AGE (IN YEARS LAST BIRTHDAY)

89

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Italy

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE CITY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

UNION MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Unknown

12b. KIND OF BUSINESS OR INDUSTRY

Unknown

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?  
YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE

4017 Parkside Drive

21206

14. FATHER'S NAME

Unknown

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

Unknown

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

656-09-4876

17. INFORMANT

Edna B. Wilson

ADDRESS

4017 Parkside Drive

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) sepsis

DUE TO, OR AS A CONSEQUENCE OF

(b) Decubiti

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c) dementia with poor PO intake

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

Probable colon cancer

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHERE ☐ AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from SEPT 25, 1987 to OCTOBER 5, 1987, that (I) (we) last saw the deceased alive on OCTOBER 5, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE

Scott Rifkin

DEGREE

MD

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

10/5/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

SCOTT RIFKIN, M.D.

22e. ADDRESS

UNION MEMORIAL HOSPITAL

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

10-10-87

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill

23d. LOCATION  
CITY OR TOWN

Brooklyn PK

COUNTY

STATE  
MD

24. FUNERAL DIRECTOR

NAME

Irvin Carroll Funeral Home

ADDRESS

112-14 W. North Ave

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

OCT - 7 1987

Julia S. Pendergast

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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10--02-87

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10--02-87



068983 OCT 20 87

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28361

2a. DECEASED NAME (TYPE OR PRINT) Lucille P. Alexander			2b. DATE OF DEATH MONTH DAY YEAR 10-11-87			2c. HOUR 9:15 AM	
3. SEX F	4. RACE B 2	5. DATE OF BIRTH MONTH DAY YEAR 10 09 06		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.	8b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3808 Greenspring Ave			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Warren Prestley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Holiday				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 239-07-7800		17. INFORMANT ADDRESS Flossie Miller 3808 Greenspring Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple cerebrovascular accidents DUE TO, OR AS A CONSEQUENCE OF: (b) Atherosclerotic cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF: (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 3/24, 1987, to 4/4, 1987, that (I) (we) last saw the deceased alive on 4/4, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. Alan Treisinger MD			DEGREE			22c. DATE SIGNED 10/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. ALAN TREISINGER MD			22e. ADDRESS 5411 OLD FREDERICK RD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-15-87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.	
24. FUNERAL DIRECTOR NAME Wm. C. Brown			25a. DATE REC'D. BY REGISTRAR 1206 W. North Ave 2/21/87		25b. REGISTRAR'S SIGNATURE OCT 19 1987		

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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069749 OCT 26 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Timothy

Alexander

2a. DATE OF DEATH  
KNOWN ESTIMATED  
☒ MONTH DAY YEAR  
10 15 19 87

2b. HOUR

3. SEX

4. RACE

5. DATE OF BIRTH

MONTH

DAY

YEAR

6. AGE (IN YEARS)

LAST BIRTHDAY

IF UNDER 1 YR.

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7c. DATE  
PRONOUNCED  
DEAD

MONTH

DAY

YEAR

2d. HOUR

7. PM

7a. BIRTHPLACE  
(STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS  
OR INDUSTRY

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

14. FATHER'S NAME

15. MOTHER'S MAIDEN NAME

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Bronchopneumonia  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Cirrhosis of liver and alcoholism  
DUE TO, OR AS A CONSEQUENCE OF  
(c) Cirrhosis of liver and alcoholism  
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  
Cirrhosis of liver and alcoholism  
19a. DATE OF OPERATION  
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  
20. AUTOPSY?  
YES ☒ NO ☐  
21a. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH  
21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19  
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  
21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK ☐ AT WORK ☐  
21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)  
21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE  
22a. I certify that I took charge of the remains described above, held on  
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion  
ACTUAL SIGNATURE Dennis F. Smyth, M.D. (THIS SPECIFY)  
M.D. ASSISTANT MEDICAL EXAMINER DATE SIGNED 10/16/87  
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS 111 Penn St. Balto.MD.  
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 10/24/87 23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION CEMETERY 23d. LOCATION CITY OR TOWN COUNTY STATE LANSDOWNE MD  
24. FUNERAL DIRECTOR NAME W.M. C. MARCH F/H, INC. ADDRESS 1101 E. NORTH AVENUE 25a. DATE REC'D. BY REGISTRAR OCT 23 1987 25b. REGISTRAR'S SIGNATURE Raymond R. Rouse

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Bronchopneumonia  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Cirrhosis of liver and alcoholism  
DUE TO, OR AS A CONSEQUENCE OF  
(c) Cirrhosis of liver and alcoholism

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  
Cirrhosis of liver and alcoholism

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on  
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE

Dennis F. Smyth, M.D.  
(THIS SPECIFY)  
M.D. ASSISTANT

MEDICAL EXAMINER

DATE SIGNED 10/16/87

EXAMINER'S NAME  
(TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS

111 Penn St.

Balto.MD.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY) BURIAL

23b. DATE

10/24/87

23c. NAME OF CEMETERY OR CREMATORY

MOUNT ZION CEMETERY

23d. LOCATION  
CITY OR TOWN

LANSDOWNE

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

NAME

W.M. C. MARCH F/H, INC.

ADDRESS

1101 E. NORTH AVENUE

25a. DATE REC'D. BY REGISTRAR

OCT 23 1987

25b. REGISTRAR'S SIGNATURE

Raymond R. Rouse

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

10074 001204

BOX COTTON FIBER

10074 001204

068483 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM WM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2836  
REG. NO.

1- STATE REGISTRAR DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH DAY YEAR		2b. HOUR			
1- WILLIEMETTER (WILAMETER)		ALFORD						<input checked="" type="checkbox"/> 10 9 19 87				M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR			
F	B	8 8 17	70 YRS.					10 9 19 87				4:25 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.			
SC		U.S.A.				Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		2156 Cecil Ave.		RETIRED		N/A									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
		MD				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2256 CECIL AVENUE 21218					
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST					
WILLIE				PARROTT		HATTIE				WILDS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
NO		N/A		DOZIER B. ALFORD		2256 CECIL AVENUE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Chronic alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Arteriosclerotic cardiovascular disease</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?	
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED											
Mario F. Golle, Jr.		M.D. Assistant		10-10-87											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
Mario F. Golle, Jr., M.D.		111 Penn St., Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE			
BURIAL		10/14/87		MOUNT AUBURN CEMETERY		BALTIMORE,						MD			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
WM. C. MARCH F/H, INC.		1101 E. NORTH AVENUE		OCT 13 1987		Julia D. [Signature]									

000100 001100

20% COTTON FIBER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other trauma or other event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		20. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
DECEASED NAME (TYPE OR PRINT)		JAMES WILLIAM ALLEN				10 15 87 M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE	BLACK	2 10 1914		73					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA	USA			BALTIMORE MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	301 MCMECHAN ST. APT. 825			LABORER					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MARYLAND		BALTO.				301 MCMECHAN APT. 825			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
JOHN ALLEN		ANNA SCOTT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		212-26-3178		GEORGE COSBY 1903 SOUTH RD. 21209					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic colon cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8-18-87</u> , 19 <u>87</u> , to <u>10-15-87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-15-87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Paul Gormley</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/19/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Paul Gormley</u>		22e. ADDRESS <u>900 Cotton Ave Balt. Md. 21229</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		23b. DATE <u>10-22-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAKWOOD CEM</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>CHARLOTTEVILLE VA. VA.</u>			
24. FUNERAL DIRECTOR NAME <u>E.L. PHILLIPS</u>		ADDRESS <u>1721 N. MONROE ST</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 23 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/BI  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE FRANCES LAST ALLEN			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 23, 1987		2b. HOUR P M 2:35						
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 7 24 16		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2019 E. 31st STREET 21218			
14. FATHER'S NAME FIRST MIDDLE LAST TINKER WILLIAMS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RAINEY RICHARDSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 228-20-4566		17. INFORMANT ADDRESS PETT ALLEN SR. 2019 E. 31st STREET					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: inline-block; vertical-align: middle; font-size: 3em; margin: 0 10px;">}</div> DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PNEUMONIA											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 10, 1987, to OCTOBER 23, 1987, that (I) (we) last saw the deceased alive on OCTOBER 23, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. P. Nazemi MD						DEGREE			22c. DATE SIGNED 10/23/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ATAOLLAH NAZEMI MD.						22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/28/87		23c. NAME OF CEMETERY OR CREMATORY GREENWOOD CH. CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE WARRENTON NC			
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. NORTH AVENUE						25a. DATE REC'D. BY REGISTRAR OCT 26 1987			25b. REGISTRAR'S SIGNATURE J. B. Anderson		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 2 8 3 1 2			
1. DECEASED NAME (TYPE OR PRINT) <b>Reuben Alperstein</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10 24 87</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 13 1910</b>		2b. HOUR <b>12:54 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shai Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Court Commissioner State Of Md.</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>BALCO</b>		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Apt. A2 21208</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Alperstein</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Levinson</b>		17. INFORMANT <b>Apt. A2 ADDRESS 21208 Ct. Mrs. Dorothy Alperstein 7204 Valley Country</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-20-8569</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Ruptured Abdominal Aortic Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>5 hours</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Probable myocardial ischemia</b>							
19a. DATE OF OPERATION <b>10/24/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured AAT</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/24 19 87</b> to <b>10/24 19 87</b> , that (I) (we) last saw the deceased alive on <b>10/24 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <b>G. Salomon M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/24/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY D. SAROMON</b>		22e. ADDRESS <b>Shai Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 25, 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth Jacob</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Carroll Pinksburg Maryland</b>	
24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. Inc. 6010 Reisterstown Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1987</b>			
				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rudner</b>			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Evelyn L. Altieri			2a. DATE OF DEATH MONTH DAY YEAR October 7, 1987		2b. HOUR M
1. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 2 3 23		6. AGE (IN YEARS [LAST BIRTHDAY]) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15 Charles Plaza		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Emmanuel Myers			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Poly Ford		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-12-5300		17. INFORMANT ADDRESS Sheila Altieri 4990 N. Mairne Drive	

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hepatic Coma

DUE TO, OR AS A CONSEQUENCE OF

(b) Metastatic Breast Carcinoma to Liver

DUE TO, OR AS A CONSEQUENCE OF

(c) PRIMARY BREAST CANCERAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH5 days10 months> 10 months

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Kathy J. Helzlsouer MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>10/7/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHY J. HELZLSOUE R MD		22e. ADDRESS JOHNS HOPKINS ONCOLOGY CENTER, BALTIMORE MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/12/87	23c. NAME OF CEMETERY OR CREMATORY King Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR OCT 09 1987	
		25b. REGISTRAR'S SIGNATURE <u>Julia Denson-Randall</u>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Their plaque remove carbon papers. Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

REG. NO.

1- BASED NAME (TYPE OR PRINT)		FIRST CLYDE		MIDDLE ANDERSON	LAST ANDERSON	2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 27, 1987		2b. HOUR 7:24 P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01/06/1941		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) unknown		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 232 N. LIBERTY 21201	
14. FATHER'S NAME CLARENCE		MIDDLE ANDERSON		LAST ANDERSON		15. MOTHER'S MAIDEN NAME MINNIE		MIDDLE STONE LAST STONE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT CLYDE ANDERSON		ADDRESS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>alcoholic encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>alcoholic hepatitis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>3 weeks</u> <u>1 month</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>sepsis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>10/9</u> 19 <u>87</u> to <u>10/27</u> 19 <u>87</u> , that (1) (we) lost saw the deceased alive on <u>10/27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dang-Vu</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>10/27/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANG-VU		22e. ADDRESS <u>601 N. Wolfe St. Balto. Md 21205</u> <u>The Johns Hopkins Medical Institution</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10-29-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR	
24. FUNERAL DIRECTOR NAME State Anat omy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR NOV 02 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please advise the coroner's office. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) FIRST (Debo) MIDDLE Lee LAST Anderson		MONTH DAY YEAR 10 30 87		710PM	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 2 8 48		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Smiley MIDDLE LAST Tillman		15. MOTHER'S MAIDEN NAME FIRST Zelma MIDDLE E. LAST Randall		17. INFORMANT ADDRESS Rev. Ralph Forrest 1010 Channing Martin Ct	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-44-5133		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE AND CEREBRAL CANCER UNK DUE TO, OR AS A CONSEQUENCE OF (c) ACQUIRED IMMUNODEFICIENCY SYNDROME UNK				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE MONTH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/22 19 87, to 10/30 19 87, that (I) (we) last saw the deceased alive on 10/30 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE Jay D. N. S. U. D.		DEGREE		22c. DATE SIGNED 10/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/4/87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
24. FUNERAL DIRECTOR Wm. C. March F/H West 4300 Wabash Avenue		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD		25a. DATE REC'D. BY REGISTRAR NOV 03 1987	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eva Anderson			2a. DATE OF DEATH MONTH DAY YEAR October 16 1987		2b. HOUR 4:20 P.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Sept 01 1946		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FT. MATT, S. C.		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD		
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A	
13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		12b. KIND OF BUSINESS OR INDUSTRY N/A
14. FATHER'S NAME FIRST MIDDLE LAST JOHN WRIGHT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRIDGETT WRIGHT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS ORA AYERS 2844 PARKWOOD AVE.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis, Infected Left hip prosthesis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from July 25 1987 to October 16 1987, that (I) (we) last saw the deceased alive on Oct 16 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) (did not) view the body after death.						
22b. SIGNATURE David A. Jung MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/16/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David A. Jung				22e. ADDRESS 2600 Liberty Hts Ave, Balt. 21225		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/19/87		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.
24. FUNERAL DIRECTOR NAME Leroy D. Gett				24a. DATE REC'D. BY REGISTRAR OCT 21 1987		
ADDRESS 4600 Liberty Hts Ave				REGISTRAR'S SIGNATURE John Anderson		

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MEDICAL CERTIFICATION

9  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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068418 OCT 14 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 8 3 7 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				2b. HOUR			
HAROLD						ANDERSON JR.		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 10 7 19 87				10 7 19 87			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. BALTIMORE CITY OR COUNTY OF DEATH					
Male	Black	Jan. 12, 1934		53 YRS.						Baltimore City					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						Baltimore City					
Maryland		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		St. Agnes Hospital		Cab Driver		Diamond Cab									
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1010 Walnut Avenue 21229					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Harold				Anderson, Sr.		Carrie		Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes				Korean War		215-30-7946		Helen Amerson		1010 Walnut Avenue		21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:															
(b) _____															
DUE TO, OR AS A CONSEQUENCE OF															
(c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
				Deputy Chief				10-7-87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Ann M. Dixon, M.D.				111 Penn St., Balto., MD				21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				10-13-87		Garrison Forest Vets Cem				Garrison, Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Marshall W. Jones, Jr F.H. 4101 Edmondson Ave. 21229				OCT 13 1987											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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069912 OCT 27 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) JOHN ADAM ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR 10 22 1987		2b. HOUR 1252 PM
3. SEX M	4. RACE B V	5. DATE OF BIRTH MONTH DAY YEAR 4 26 35	6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.		
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. COUNTY County	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Walker Anderson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Knight		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216 30 0845	17. INFORMANT ADDRESS Ruth R. Anderson 3007 Ferndale Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac dysrhythmias DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomyopathy, S/PMI PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HTN					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from OCT 21 1987 to OCT 22 1987, that (I) (we) last saw the deceased alive on OCT 21 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Katharine S. Harrison MD			22c. DATE SIGNED 10/22/87		DEGREE MD
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHARINE HARRISON			22e. ADDRESS SINAI HOSPITAL BALTO 21215		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/26/87	23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown, Md.
24. FUNERAL DIRECTOR NAME Wm C. March F/H West			ADDRESS 4300 Wabash Ave.		25a. DATE REC'D BY REGISTRAR OCT 26 1987

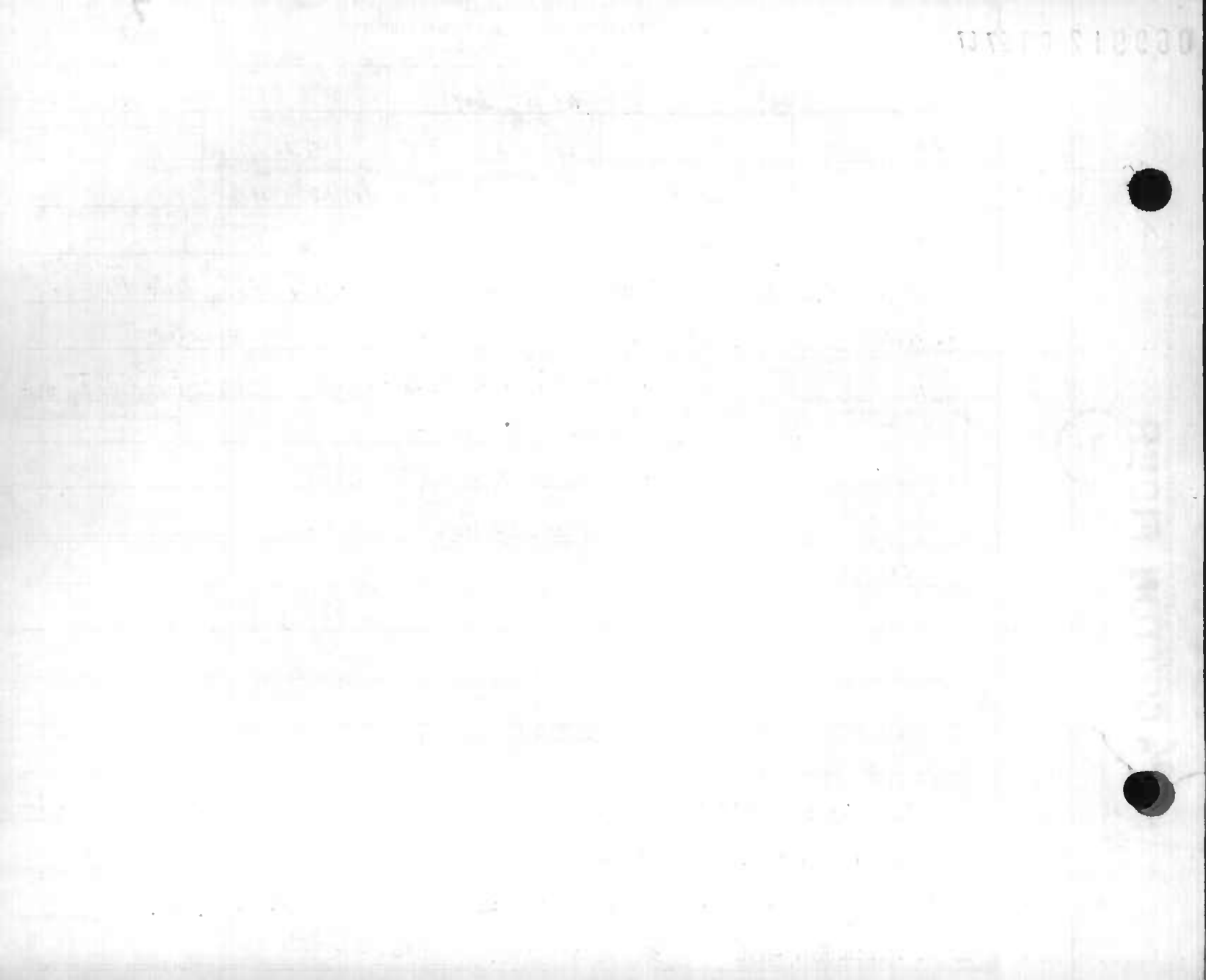
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or has 18 others any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LILLIAN PEARL ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR 10 9 87			2b. HOUR 9 <sup>10</sup> P.M.				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12/13/1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WRAPPER		12b. KIND OF BUSINESS OR INDUSTRY MAY COMPANY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD G. TAYLOR					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORA A. RIPPEON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-22-6086		17. INFORMANT ADDRESS MARYLAND 21228 FLORA HAMSHEY 109 DELREY AVE. CATONSVILLE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Arteriosclerotic Coronary Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Chronic Atrial Fibrillation</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>James, MD</u>						DEGREE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Orastes Moldes, MD						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				
22e. ADDRESS ST. AGNES HOSPITAL BALTIMORE, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/13/87		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE CATONSVILLE MD 21228						25a. DATE REC'D. BY REGISTRAR OCT 13 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages must 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

John

FIRST

MIDDLE

LAST

S

Andrews

2a. DATE OF DEATH

MONTH

DAY

YEAR

10 25 87

2b. HOUR

4:58 M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

XIX 12 26 14 890

6. AGE (IN YEARS LAST BIRTHDAY)

96

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Austria

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Church Hospital

12a. USUAL OCCUPATION

Millwright

12b. KIND OF BUSINESS OR INDUSTRY

Sparrows Point

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

3207 McElderry St. 21205

14. FATHER'S NAME

Not Known

MIDDLE

LAST

Ondrijko

15. MOTHER'S MAIDEN NAME

Mary

MIDDLE

LAST

Not Known

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

17. INFORMANT

ADDRESS

216-10-1178

Edward D. Andrews 438 S. Drew St. 21224

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Conjunctive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

Septicemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

Pneumonia

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☒

22c. DATE SIGNED

10/25/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Zachary I. Hodges M.D.

22e. ADDRESS

100 N. Broadway St

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

10-28-87

23c. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

23d. LOCATION

Baltimore Maryland

STATE

24. FUNERAL DIRECTOR  
NAMEDuda-Ruck Funeral Home of Dundalk  
7922 Wise Ave. Dundalk, MD 21222

25a. DATE REC'D. BY REGISTRAR

OCT 28 1987

25b. REGISTRAR'S SIGNATURE

Julia T. [Signature]

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OF THE

UNIVERSITY OF

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 1 is marked or item 18 shows cardiac, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE: OR <sup>OP</sup> ) FIRST MIDDLE LAST <b>HOWARD E. APPELTOFFT JR</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>10 14 87</b>					2b. HOUR <b>8:25 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 27 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.			7. # UNDER 1 YEAR MONTHS DAYS <b>14 87</b>		
7a. BIRTHPLACE STATE OR FOREIGN <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>LUMBER</b>		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>204 NEWBURG AVE 21228</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>HOWARD E. APPELTOFFT SR.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FRIEDA SCHROEPFER</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>216-01-6683</b>		17. INFORMANT <b>RAMONA APPELTOFFT</b>		ADDRESS <b>CATONSVILLE MD 204 NEWBURG AVE 21228</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac pulmonary arrest (anterior MI)</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>p. thal. (CVA)</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10/10/87</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>in shock</i>											
19a. DATE OF OPERATION <b>10/12</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>10/12</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <b>10/12</b> , 19 <b>87</b> , to <b>10/14</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/14</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>T J Campen</i>					DEGREE			22c. DATE SIGNED <b>10/14/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T J Campen</b>					22e. ADDRESS <b>St. Agnes Hosp., Baltimore, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/17/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAKEVIEW MEMORIAL PARK SYKESVILLE</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>CARROLL MARYLAND</b>				
24. FUNERAL DIRECTOR NAME <b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOMES</b>						25a. DATE RECEIVED BY REGISTRAR <b>OCT 16 1987</b>					
1630 EDMONDSON AVE CATONSVILLE MD 21228						25b. REGISTRAR'S SIGNATURE <i>Julia B. ...</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 28382			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Bernard M. Armstrong</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10 5 87</b>			
3. SEX <b>M</b>		4. RACE <b>B 2</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 27 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>BCITY</b>		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Wilson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Armstrong</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-07-5920</b>		17. INFORMANT ADDRESS <b>Sinai Hospital of Baltimore</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>intracranial hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>pituitary tumor</b>							
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>N/A</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <b>N/A</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>David Evans</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/5/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Evans</b>				22e. ADDRESS <b>Sinai Hospital of Baltimore</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/14/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. c. March F/H West 4300 Wabash Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 13 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Benson-Randall</b>	

BP \_\_\_\_\_



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SANDRA SANDRA</b>		EILEEN ARMSTRONG		DATE OF DEATH OCT 30 1987		7b. HOUR 2:09 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH OCT 25 1954		6. AGE (IN YEARS LAST BIRTHDAY) 33	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec.-Clms Adj.		12b. KIND OF BUSINESS OR INDUSTRY Warehouse 570	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ishmon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agatha Pettis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-62-5751	
17. INFORMANT ADDRESS Agatha Shanks 4532 Marble Hall Rd. 21239		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) ADULT RESPIRATORY DISTRESS SYNDROME DUE TO, OR AS A CONSEQUENCE OF (c) SYSTEMIC LUPUS CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 4 weeks 12 years		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CANDIDA MENINGITIS.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (this hospital) attended the deceased from Oct 2 1987, to Oct 30 1987, that (we) lost the deceased alive on Oct 30 1987, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) not view the body after death.		22a. SIGNATURE Loutfi Aboussouan MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) LOUTFI ABOUSSOUAN		22c. ADDRESS GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD		22d. DATE SIGNED 10/30/87		23a. BURIAL, CREMATION, REMOVAL Burial	
23b. DATE 11-04-87		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.		24. FUNERAL DIRECTOR NAME Marshall W. Jones, Jr. F.H. ADDRESS 4101 Edmondson Ave 21229	
25a. DATE REC'D. BY REGISTRAR NOV 03 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		26. DATE OF DEATH OCT 30 1987		27. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



068804 OCT 16 1987

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 8 3 3 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Jean Arrington</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/13/87</b>			2b. HOUR <b>2:30p<sup>M</sup></b>			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YRS <b>6 3 36</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13a. STATE <b>MD</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES HOLLAND</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LILLIAN SPEARS</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>LOUISE HOLLAND 926 ABBOTT COURT</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <del>CONGESTIVE CARDIOMYOPATHY</del> DUE TO, OR AS A CONSEQUENCE OF (b) <del>CIRRHOISIS WITH ASCITES</del> DUE TO, OR AS A CONSEQUENCE OF (c) <del>ETHLY ALCOHOL ABUSE</del>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 7</b> , 19 <b>87</b> , to <b>Oct. 13</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/13/87</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Kenneth D. Byerly</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/13/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kenneth D. Byerly, M.D.</b>			22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. Broadway Baltimore, MD 21231</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>10/15/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CEM.</b>		23d. LOCATION <b>BALTIMORE</b> COUNTY <b>MD</b>		
24. FUNERAL DIRECTOR NAME <b>WM. C. MARCH F/H 1101 E. NORTH AVENUE</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 15 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





68793 OCT 16 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH2 8 3 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Kulon		E.		Ashe				ESTIMATED		10/		11/		87		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	black	7 7 1924		63 YRS.						10/		11/		87		9:20 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Va		USA		WIDOWED		DIVORCED		Baltimore City,								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		Bon Secour Hospital		Retired		Post Office											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12 N. Ashburton Street									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
James		Virginia															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		224-20-9248		Henrietta Ashe		12 N. Ashburton Street											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a)		Hypertensive Cardiovascular Disease															
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		Diabetes Mellitus															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Ann M. Dixon, M.D.		M.D. Deputy Chief		10/12/87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Ann M. Dixon, M.D.		111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		10/15/87		Md Nat Memorial Park		Laurel											
24. FUNERAL DIRECTOR NAME		ADDRESS		25. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Wm. C. March F/H West		4300 Wabash Avenue		OCT 15 1987		Julia Dendron-Randall											

DIVISION OF VITAL RECORDS, 201 W. BRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))



068607 OCT 15 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frank K Augins Jr.			2a. DATE OF DEATH MONTH DAY YEAR 10 10 87			2b. HOUR 12:12p.m.		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 05 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore VA Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		
12b. KIND OF BUSINESS OR INDUSTRY Towson State		13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 808 E Cold Spring LN 21212		14. FATHER'S NAME FIRST MIDDLE LAST Frank		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Gardner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-01-2182		17. INFORMANT ADDRESS Clara A. Augins 808 E Cold Spring LN				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Cardiovascular Failure DUE TO, OR AS A CONSEQUENCE OF (b). Metastatic Prostatic Dissem Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c). Severe generalized vascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10-9 6pm-10-10 12pm								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10								
19a. DATE OF OPERATION 10-9-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ischemic Right Arm - Embolization			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/25, 19 87, to 10-10-87, that (II) (we) lost saw the deceased alive on 10-10, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Gregory P. Midis MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-11-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory P. Midis				22e. ADDRESS Box 62, Univ of MD Hosp, 225. Greenst				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/15/87		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS, MD		
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE				25a. DATE REC'D. BY REGISTRAR OCT 14 1987		25b. REGISTRAR'S SIGNATURE Via Roden-Rodden		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or else.

Handwritten notes and calculations, including a table with columns labeled "Date", "Description", and "Amount". The text is written in cursive and is mostly illegible due to fading and bleed-through.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Dolores Y. Ausherman</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>10 19 87</u>		2b. HOUR <u>4:35</u> A.M.	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>10 12 30</u>	
6. AGE (IN YEARS LAST BIRTHDAY) <u>57</u> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>City</u> MD.			
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Baltimore General Hosp.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <u>MD.</u>			
13b. COUNTY <u>Anne Arundell</u>		13c. CITY OR TOWN <u>Glen Burnie</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <u>510 Kent Road / 21061</u>		14. FATHER'S NAME FIRST MIDDLE LAST <u>Charles Y. Chaney</u>			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Helen L. Stoner</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>UNKNOWN</u>			
16b. SOCIAL SECURITY NO. <u>218242050</u>		17. INFORMANT ADDRESS <u>Wilmer D. Ausherman, Same as 13</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Breast Cancer, Metastatic Ca of brain</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/23</u> , 19 <u>87</u> , to <u>10/19</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>10/19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did); (did not) view the body after death.					
22b. SIGNATURE <u>Cheng Wai-Fung</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10/19/87</u>	
22d. ADDRESS <u>CHENG, WAI-FUNG</u>		22e. ADDRESS <u>South Baltimore General Hosp.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Oct. 21, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Glen Burnie AA MD</u>		24. FUNERAL DIRECTOR NAME <u>James S. Kirkley, Glen Burnie, MD</u>			

MEDICAL CERTIFICATION

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial home (permit). Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or kept, 18 should be marked or kept. If a medical examination is required, it should be marked or kept.)

Enclosure

214

(6)

to the first floor

MD - General Electric

Cherry

218-219

(see page 2)

in the first floor

General Electric

214

Cherry

214

214



070479 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										STATE OF MARYLAND										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28388									
1. DECEASED NAME (TYPE OR PRINT) Sean P. AVERY										2a. DATE KNOWN OF DEATH ESTIMATED 10 27 1987										2b. HOUR 4:37 AM																													
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 23, 1965				6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 10 27 1987				2d. HOUR 4:37 AM																															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida				7b. CITIZEN OF WHAT COUNTRY? United States						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.																																			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student				12b. KIND OF BUSINESS OR INDUSTRY College																																			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12 Pitt Court 20850																																					
14. FATHER'S NAME FIRST MIDDLE LAST William M. Avery					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne M. Pumphrey																																												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-90-2605				17. INFORMANT ADDRESS Anne M. Avery same as #13																																									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries with complications DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:55 PM 10-16-87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/fixed object impact.																																									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Taylor Ave. east of, Balto. City MD																																									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																	
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 10-27-87																																							
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn St., Balto., MD 21201																																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct. 30, 1987		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Maryland																																							
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave. Rockville, Maryland 20850				25a. DATE REC'D. BY REGISTRAR OCT 30 1987				25b. REGISTRAR'S SIGNATURE [Signature]																																									

07/84  
25M

DHMH - 17  
(VR A15 ME (5))

010116 104-501

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MADE IN U.S.A.



OCT 30 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Geneva Ayers</b>			2a DATE OF DEATH MONTH DAY YEAR <b>10 14 87</b>		2b HOUR <b>5<sup>21</sup> A M</b>
3 SEX <b>F</b>	4 RACE <b>B</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>11 4 1918</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>FT. MOTTE, S.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. MD.</b>	
10 CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Liberty Medical Center</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD</b>		13b COUNTY <b>BALTO.</b>		13c STREET ADDRESS / ZIP CODE <b>3500 FAIRVIEW AVE. 21216</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>SIPPSIO FLOYD</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EVA F. ANDERSON</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17 INFORMANT ADDRESS <b>LILTON AYERS 6806 BROMPTON RD.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia with lung abscess.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory failure 20 to 1</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <b>Renal Failure.</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8-12-1987</b> to <b>9-14-1987</b> , that (I) (we) last saw the deceased alive on <b>9-14-1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R.M. Shah M.D.</b>				22c. DATE SIGNED <b>10/14/87.</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.M. SHAH. M.D.</b>				22e. ADDRESS <b>LIBERTY Medical Center 2600 LIBERTY HT AVE, BAL. MD. 21215.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/19/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>		24 FUNERAL DIRECTOR NAME ADDRESS <b>LEROY O. DYETT 4600 LIBERTY HEIGHTS</b>			
25. DATE RECEIVED BY REGISTRAR		25. REGISTRAR'S SIGNATURE <b>John P. ...</b>			

BP

RECEIVED  
FEB 11 1961

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28390	
1. DECEASED NAME (TYPE OR PRINT) <b>MISUNG BAECK</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>10 26 1987</b>	
1. SEX <b>FEMALE</b> 4. RACE <b>KOREAN</b> 5. DATE OF BIRTH MONTH <b>APRIL</b> DAY <b>13</b> YEAR <b>1980</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>7</b> YRS. 7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> 8. IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD <b>10 26 1987</b> 2d. HOUR <b>6P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KOREA</b> 7b. CITIZEN OF WHAT COUNTRY? <b>KOREA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>	
11. CITY OR TOWN OF DEATH <b>Baltimore</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STUDENT</b> 12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>COCKEYSVILLE</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>21030 #101 208 DUKE OF KENT COURT</b>	
14. FATHER'S NAME FIRST <b>Hyong</b> MIDDLE <b>AM</b> LAST <b>BAEK</b>										15. MOTHER'S MAIDEN NAME FIRST <b>Jin</b> MIDDLE <b>H</b> LAST <b>CHO</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. <b>213 08 0733</b>										17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Head injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). DUE TO, OR AS A CONSEQUENCE OF (c).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR <b>5:10</b> AM <b>10-23-1987</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Pedestrian struck by auto.</b>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b> 21f. LOCATION STREET <b>Greenside Dr.</b> CITY OR TOWN <b>Balto.</b> COUNTY <b>Balto.</b> STATE <b>MD</b>											
22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Accident</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> and in my opinion death resulted from: <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Charles P. Kokes</b> TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>10-27-87</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Charles P. Kokes, M.D.</b> ADDRESS <b>111 Penn St., Balto., MD 21201</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b> 23b. DATE <b>10 29 1987</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b> 23d. LOCATION CITY OR TOWN <b>Timonium Balto.</b> COUNTY <b>BALTO.</b> STATE <b>MD</b>											
24. FUNERAL DIRECTOR NAME <b>EVANS CHAPEL OF CHIMES</b> ADDRESS <b>YORK ROAD</b> 25a. DATE REC'D. BY REGISTRAR <b>OCT 29 1987</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rodney</b>											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

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070590 NOV-387

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Robert Bailey			2a. DATE OF DEATH MONTH DAY YEAR 10-25-87		2b. HOUR 1:30a
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 08-28-18		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 231 S. Broadway St. 2nd Fl.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 177-14-1637		17. INFORMANT ADDRESS Dave Pumphrey	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiovascular failure DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Degenerative joint dis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.					
22b. SIGNATURE GUY A. CARRENARD, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 242 South Broadway Baltimore, Md. 21231		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 10-30-87		23c. NAME OF CEMETERY OR CREMATORY Mt Zion	
23d. LOCATION CITY OR TOWN Balto Co		COUNTY		STATE MD	
24. FUNERAL DIRECTOR NAME Irvin Carroll		ADDRESS 1712-14 W. North Ave.		25a. DATE REC'D. BY REGISTRAR NOV 02 1987	
		25b. REGISTRAR'S SIGNATURE Julia Sanders-Rodgers			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the Medical Examiner and the coronial system should be notified.



070200 NOV-307



COY. A. CARREARD, A.D.  
242 South Broad St.  
Baltimore, Md. 21201

071345

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28392

1. DECEASED NAME (TYPE OR PRINT) HERMAN Herman BAILEY Bailey			2a. DATE OF DEATH MONTH DAY YEAR 10 / 30 / 1987			2b. HOUR 10 <sup>00</sup> A.M.	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 / 5 / 15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SAM BAILEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE PORTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219104228		17. INFORMANT ADDRESS BEATRICE SCOTT 2245 W. FAYETTE ST			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca y Prostate gland DUE TO, OR AS A CONSEQUENCE OF (b) Obstructive uropathy DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.  
CHF

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/13, 19 87, to 10/30, 19 87, that (I) (we) lost saw the deceased alive on 10/30, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Beltran				DEGREE MD		22c. DATE SIGNED 10/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. BELTRAN				22e. ADDRESS 1940 W. BALTIMORE ST, BALTO, 21223			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/5/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION Arnold, AAG Maryland STATE	
24. CHURCH OR FUNERAL HOME FUNERAL SERVICE, PA 1300 ELTAW PLACE				25a. DATE REC'D. BY REGISTRAR NOV 09 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEATRICE FRITZ BAILEY			2a. DATE OF DEATH MONTH DAY YEAR 10 8 87			2b. HOUR 11:53 AM				
3 SEX F		4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR APR. 30. 1931		6. AGE (IN YEARS (LAST BIRTHDAY)) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UN. OF MD. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK-TYPIST		12b. KIND OF BUSINESS OR INDUSTRY BOARD OF EDUCATION		
13a. STATE MD.			13b. COUNTY ST. MARY'S		13c. CITY OR TOWN TALL TIMBERS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST GARFIELD M. FRITZ			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARYL F. ROSS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 391-26-8299	
17. INFORMANT JEAN BAILEY			ADDRESS SAME AS 13E.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) MACROGLOBULINEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Oct 12 1987, to Oct 13 1987, that (I) (we) last saw the deceased alive on Oct 13 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Flavio Kruter			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Oct 13 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FLAVIO KRUTER			22e. ADDRESS 22 SOUTH GREENE ST							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10-16-87		23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE EPISCOPAL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE VALLEY LEE, ST. MARY'S, MD.			
24. FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.						25a. DATE REC'D. BY REGISTRAR OCT 19 1987		25b. REGISTRAR'S SIGNATURE Julia Davis		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial transit permit. They please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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OCT 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filled with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.																			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR															
3. SEX				4. RACE				5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)				7. BALTIMORE CITY OR COUNTY OF DEATH							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13b. STREET ADDRESS / ZIP CODE				13c. STREET ADDRESS / ZIP CODE							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
18a. Paul				18b. Harless				18c. Not Known				18d. No				18e. 213-30-6735				18f. Yvonne E. Cramer 7866 St. Monica Dr. 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>				DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain Stem Herniation</u>				DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intracranial Hemorrhage</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>Adelaide S. Robb MD</u>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>10/22/87</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Adelaide S. Robb MD</u>				22e. ADDRESS <u>4940 Eastern Avenue Beltsville MD</u>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>10-24-87</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Maryland</u>											
24. FUNERAL DIRECTOR NAME <u>Duda-Ruck Funeral Home of Dundalk</u>				ADDRESS <u>7922 Wise Ave. Dundalk, MD 21222</u>				25a. DATE REC'D. BY REGISTRAR <u>OCT 28 1987</u>				25b. REGISTRAR'S SIGNATURE <u>Julia Swinson-Pandey</u>											

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LEONARD BANKS</b>			2a DATE OF DEATH MONTH DAY YEAR <b>10-21-87</b>		2b HOUR <b>945 A.M.</b>	
3 SEX <b>MALE</b>		4 RACE <b>CAUCASIAN</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>06-17-1912</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LITHUANIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Levindale Home &amp; H</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>CITY OF Baltimore MD.</b>		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POTTER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>POTTERY</b>		13a STREET ADDRESS, ZIP CODE <b>APT. 1011 21215 2500 W. Belvedere Avenue</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>NORMAN BANKS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HANNAH UNKNOWN</b>		13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>080-05-5380</b>		17 INFORMANT <b>NORTON S. BANKS</b> <b>6812 NAVAJO DR. BALTO., MD 21209</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>GANGRENE OF RT. FOOT, NON-HEALING B/LK AMPUTATION STUMP, PVD RENAL FAILURE</b>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (this hospital) attended the deceased from <b>9/27</b> 19 <b>87</b> to <b>10/21</b> 19 <b>87</b> that (we) lost saw the deceased alive on <b>10/21</b> 19 <b>87</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.		22b SIGNATURE <b>Leonard</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22c DATE SIGNED <b>10/21/87</b>		22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELLITA O. KIN</b>		22e ADDRESS <b>Levindale Harbor GERIATRIC CENTER + Hospital</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL/BURIAL</b>		23b DATE <b>OCT. 23, 1987</b>		23c NAME OF CEMETERY OR CREMATORY <b>(KNESSETH TIFERETH ISRAEL)</b>		
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		24b ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25 DATE REC'D BY REGISTRAR <b>OCT 26 1987</b>		
25b REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DANIEL LEONARD

TO HOSPITAL OR ATTENDING PHYSICIAN: This death certificate is to be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed and signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. This permit will be attached to the body of the deceased and taken to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, you must indicate the nature of the injury on the back of this certificate.



JOSE BONNISTER

## MEDICAL CERTIFICATION

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other treatment, the medical examiner must be

BP\_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

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Item 18a, 21a, b, c, d, e, f, 22a		10-30-87 dw		STATE OF MARYLAND		28397	
FOR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE					
1- STATE 6632 per med exam		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR HOUR	
Richard Barksdale				10 4 19 87		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		BLACK		1 16 51		36 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
VA		USA				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Johns Hopkins Hospital		UNEMPLOYED		N/A	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD				BALTIMORE		904 BENNETT PLACE 21223	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
WILLIAM BARKSDALE		LOLA MORTON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		220-52-6720		ANDREW PALMER		165 N. MICHIGAN/ CA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Amoxapine intoxication							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF			
		(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-4 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Subject used amoxapine	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		unknown	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .		22b. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		10/5/87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Mario F. Golle, Jr, M.D.		111 Penn St.				Balto, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		10/8/87		CEDAR HILL CEMETERY		ANNE ARUNDEL CO. MD	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
WM. C. MARCH F/H 1101 E. NORTH AVENUE		OCT 07 1987		John Davidson			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3-RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

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UNION MANUFACTURING

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STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 8 3 9 0

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VADA Marie BARLOW			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 8, 1987		2b. HOUR 11:40 A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 5 1908		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 79	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeping		12b. KIND OF BUSINESS OR INDUSTRY Domestic Help	
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2411 Carolyne Ave., Balto. 21219	
14. FATHER'S NAME FIRST MIDDLE LAST John Albert Myers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olivia Maude Toms		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-50-5119	
17. INFORMANT ADDRESS Samuel E. Sheeler, 14318 Phoenix Ave. West		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cancer</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 1 hr			
19a. DATE OF OPERATION 8/20/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Cancer		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21c. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/18/87 to 10/8/87 that (I) (we) last saw the deceased alive on 10/8/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.		22b. SIGNATURE Sullivan		22c. ADDRESS JHH 600 N. Wille St. Balto. Md. 21205		22d. DATE SIGNED 10/8/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/12/87		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Martin D. Lawson		25. DATE REC'D. BY REGISTRAR OCT 13 1987		26. REGISTRAR'S SIGNATURE Julia Burdick			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial. (1705/108-001)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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Oct 13 1935

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please make separate papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DOROTHY		FIRST BARNES		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR 10 24 87				2b. HOUR 620 PM	
3. SEX F		4. RACE B V		5. DATE OF BIRTH MONTH DAY YEAR 9 15 10				6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty MED. CENTER						12a. USUAL OCCUPATION (NAME OF WORK FOR MOST OF WORKING LIFE) Domestic				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALT.		13c. CITY OR TOWN BALT.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 717 DRUID AVE BALTIMORE 21217					
14. FATHER'S NAME FIRST MIDDLE LAST William Perkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Alston									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 207-24-8862		17. INFORMANT Ellen C. Perkins				ADDRESS 1701 Eutam P1					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis, pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Chronic obstructive pulmonary Disease													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 10/24 19 87 to 10/24 19 87, that (I) (we) lost saw the deceased alive on 10/24 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Michael Kazak		DEGREE		22c. DATE SIGNED 10/24/87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL KAZAK MD		22e. ADDRESS 6810 BONNIE RIDGE AVE BALTIMORE 21219											
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE 10-28-87		23c. NAME OF CEMETERY OR CREMATORY White Rock Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore county MD					
24. FUNERAL DIRECTOR NAME KIM E. BROWN		1206 W NORTH AVE		25a. DATE REC'D. BY REGISTRAR OCT 28 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

BP \_\_\_\_\_

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07051 15070

1. DECEASED NAME (TYPE OR PRINT) <b>HENRY A. BARNES</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 14 19 87</b>		2b. HOUR <b>9:14 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 21 48</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>39 YRS.</b>		IF UNDER 1 YR MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10 14 19 87</b>		2d. HOUR <b>9:14 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NC</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>(auto) 1800 blk. W. Lafayette Ave.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AMERICAN SALES</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FULLTIME</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>BALTIMORE</b>				13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1813 W. LAFAYETTE AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES PETTAWAY</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA BARNES</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>214-50-5354</b>				17. INFORMANT <b>BERNADETTE BARNES</b>				ADDRESS <b>1813 W LAFAYETTE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun wound to the back of the chest with injury</b> DUE TO, OR AS A CONSEQUENCE OF to neck Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>xxx 10-14-19 87</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject shot.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>(auto) street</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1800 blk. W. Lafayette Ave., Balto. City, MD</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i>				TITLE (SPECIFY) <b>Assistant</b>				MEDICAL EXAMINER <b>Mario F. Golle, Jr., M.D.</b>				DATE SIGNED <b>10-14-87</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Mario F. Golle, Jr., M.D.</b>				ADDRESS <b>111 Penn St., Balto., MD 21201</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>10/19/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>ARBUTUS MD</b>			
24. FUNERAL DIRECTOR NAME <b>WM. C. F/H INC.</b>				ADDRESS <b>1101 E. NORTH AVENUE</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 16 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Radcliff</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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**87-** FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of those

### MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) <b>ROBY Franklin BARNES JR.</b>		2a. DATE OF DEATH MONTH YEAR DAY <b>10/02/1987</b>		2b. HOUR <b>145 P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01/19/1923</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>64</b>		7b. IF UNDER 24 HRS HOURS MIN. <b>64</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Correction officer</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Prison</b>		13a. STREET ADDRESS / ZIP CODE <b>1131 Liberty Rd. 21784</b>		13b. CITY OR TOWN <b>Sykesville</b>	
13c. STATE <b>Md.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1131 Liberty Rd. 21784</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Roby F. BARNES Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Shipley</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>21716 4723</b>		17. INFORMANT ADDRESS <b>Jeffrey BARNES Sykesville, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Squamous Cell CA right mainstem bronchus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>House Officer</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/2/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>		22e. ADDRESS <b>Sinai Hospital</b>		23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>	
23b. DATE <b>10-6-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Freedom Cemetery</b>		23d. LOCATION CITY OR TOWN STATE <b>Sykesville Carroll Md</b>	
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b>		ADDRESS <b>Sykesville, Md.</b>		25. DATE RECEIVED BY REGISTRAR <b>OCT 06 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. REGISTRAR'S SIGNATURE <b>[Signature]</b>			





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Josephine Barrett					October 15, 1987					5:05 PM	
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	Black		MONTH DAY YEAR 8/25/20		67 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Va.	USA				Baltimore City MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			Maryland General Hospital								
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Md.						Baltimore				1825 Etting St. 21217	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				ADDRESS			
FIRST MIDDLE LAST William Briggs				FIRST MIDDLE LAST Phyllis Briggs							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT					
				218-18-0230		Deborah Evans 1825 Etting St. 21217					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory/Cardiac Arrest; Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Profound Depression</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Uremia</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 13, 19 87</u> to <u>October 15, 19 87</u> that (I/we) lost saw the deceased alive on <u>October 15, 19 87</u> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) not view the body after death.											
22b. SIGNATURE <u>Lois Clements, M.D.</u>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10/16/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>L. Clements MD</u>				22e. ADDRESS <u>c/o Maryland General Hospital</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>10/22/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cem.</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Westport Md.</u>		
24. FUNERAL DIRECTOR <u>Estep Bros. 1300 Eutaw Place</u>						25a. DATE REC'D. BY REGISTRAR <u>OCT 26 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Darden-Randall</u>			



068982 OCT 20 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

28403

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Peter MIDDLE: P LAST: Barzyk Jr.			2a. DATE OF DEATH MONTH: 10 DAY: 17 YEAR: 87		2b. HOUR: 9:30 A.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: June DAY: 29 YEAR: 1916		6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.	IF UNDER 1 YEAR: MONTHS: DAYS: IF UNDER 24 HRS: HOURS: MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.		
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Mercy Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Balto. Co. Dept of Education		12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland 13b. COUNTY: Baltimore 13c. CITY OR TOWN: Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS: 1521 Bethlehem Ave. 21222	
14. FATHER'S NAME FIRST: Peter MIDDLE: P. LAST: Barzyk, Sr.		15. MOTHER'S MAIDEN NAME FIRST: Mary MIDDLE: LAST: Krajewska			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]: No		16b. SOCIAL SECURITY NO.: 173-07-7664		17. INFORMANT ADDRESS: Julia Barzyk 1521 Bethlehem Ave. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent Ventricular Tachycardia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR: A.M. MONTH: DAY: YEAR: 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET: CITY OR TOWN: COUNTY: STATE:	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE: <u>Besha Z. Hall, MD</u>		DEGREE: ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED: 10/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT):		22e. ADDRESS:			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		23b. DATE: 10-21-87	23c. NAME OF CEMETERY OR CREMATORY: St. Stanislaus		23d. LOCATION CITY OR TOWN: Baltimore COUNTY: Maryland STATE:
24. FUNERAL DIRECTOR NAME: Duda-Ruck Funeral Home of Dundalk		ADDRESS: 7922 Wise Ave. Dundalk, MD 21222		25. DATE REC'D. BY REGISTRAR: OCT 19 1987 26. REGISTRAR'S SIGNATURE: [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

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BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR					REG. NO.				
2a DECEASED NAME (TYPE OR PRINT) <b>Ruth GERTRUDE Basch</b>					2b DATE OF DEATH MONTH DAY YEAR <b>10-9-87</b> 2c HOUR <b>7:25 PM</b>				
3 SEX <b>Female</b>		4 RACE <b>CAUCASIAN</b> <del>WHITE</del>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 15 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> <del>79</del> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>225</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Levindele</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13e STREET ADDRESS / ZIP CODE				
13a STATE <b>MARYLAND</b>		13b COUNTY		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3912 FORDS LANE APT. 204 (21215)	
14 FATHER'S NAME FIRST MIDDLE LAST <b>BERNHARD LEVI</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>AUGUSTE UNKNOWN</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>					16b SOCIAL SECURITY NO <b>213-16-0491</b>		17 INFORMANT ADDRESS <b>MRS. BETTE VOLLWEILER</b> 4016 FORDS LANE APT. 2D (21215)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (this hospital) attended the deceased from <b>4/27</b> , 19 <b>87</b> , to <b>10/9</b> , 19 <b>87</b> , that (we) last saw the deceased alive on <b>10/9</b> , 19 <b>87</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.									
22b SIGNATURE <b>[Signature]</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>10/10/87</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELYA O. KN</b>					22e ADDRESS <b>MD LEVINDALE HEBRON &amp; EMATRIC CENTER + HO</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b DATE <b>10-11-87</b>		23c NAME OF CEMETERY OR CREMATORY <b>CHEVRA AHAVAS CHESD</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>RANDALLSTOWN BALTIMORE MD.</b>		
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS. 6010 REISTERS-TOWN ROAD BALTIMORE, MARYLAND (21215)</b>						25a DATE REC'D. BY REGISTRAR <b>OCT 15 1987</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 60M 7/B4  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1- OCCUPIED NAME (TYPE OR PRINT) Charles P. Basile			2a DATE OF DEATH MONTH DAY YEAR 10-4-87			2b HOUR 10:00 <sup>a</sup>			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 6-4-1917		6 AGE (IN YEARS LAST BIRTHDAY) 70 yrs.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3855 Shannon Drive				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b KIND OF BUSINESS OR INDUSTRY Md. Cup Corp.	
13a STATE Md.			13b COUNTY		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET ADDRESS / ZIP CODE 3855 Shannon Drive 21213									
14 FATHER'S NAME FIRST MIDDLE LAST James Basile				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b SOCIAL SECURITY NO. WWII		17 INFORMANT Laura Basile		ADDRESS 3855 Shannon Drive 21213		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (b) ISCHEMIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) CORONARY ARTERY DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MMCO 1976 5 yrs. + 10 yrs. +									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)			
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (we) this hospital) attended the deceased from July 19 84, to 4 October 19 87, that (we) lost saw the deceased alive on September 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did) not view the body after death.									
22b SIGNATURE George N. Moran, MD.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/5/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. GEORGE MORAN					22e ADDRESS Union Memorial Hospital				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10-7-87		23c NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24 FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213						25a DATE REC'D. BY REGISTRAR OCT 06 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Pandey	

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT) <b>Robert Lee BATES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-19-87</b>		2b. HOUR <b>8:00 P.M.</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>09-24-24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SURRY, N.C. Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Balto. Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machine Operator, Koppers</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Co.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>-----</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1531 Byrd St. Balto. Md. 21230</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Columbus ----- Bates</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah ----- Carter</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES <b>No</b>		16b. SOCIAL SECURITY NO. <b>244-30-9737</b>		17. INFORMANT ADDRESS <b>Mrs. Doris Bates, Same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Empyema</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Amorphous lateral sclerosis</b>					
19a. DATE OF OPERATION <b>2</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>August 17, 1987</b> to <b>October 19, 1987</b> , that (I) (we) last saw the deceased alive on <b>October 19, 1987</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Rafael E. Espinosa</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/19/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rafael E. Espinosa</b>		22e. ADDRESS <b>3001 S. Hanover St, Ba H MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>10/22/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process Inc.</b>	
23d. LOCATION CITY OR TOWN COUNTY <b>Catonsville, Balto. Co. Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>OCT 20 1987</b>			
24. FUNERAL DIRECTOR NAME <b>Balto. Md. 21230</b>		ADDRESS <b>McCully Funeral Home, 130 E. Fort Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 20 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>Jordan Hordell</b>					

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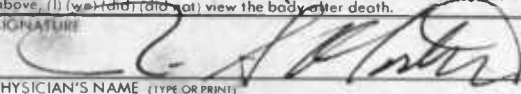
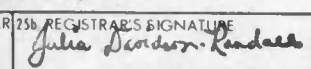
00220 OCT 21 83

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 28407			
1. DECEASED NAME (TYPE OR PRINT) <b>BAUER MARIA BAUER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10 31 87</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 7, 1907<sup>AR</sup></b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Yugoslavia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Yugoslavia</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANCIS SCOTT KEY MED. CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Essex</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Harcos</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>212 44 4983</b>		17. INFORMANT <b>Laszlo Kuczmog, Step-Son</b>		17. ADDRESS <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ISCHEMIC BOWEL</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10/30/87 - 10/31/87</b> <b>10/29/87 - 10/31/87</b> <b>10/28/87 - 10/31/87</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>STATUS POST MYOCARDIAL INFARCTION</b>							
19a. DATE OF OPERATION <b>10/23/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ACUTE ABDOMEN</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/21</b> , 19 <b>87</b> , to <b>10/31</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/31</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/31/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ron A. Morton Jr. M.D.</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Cremation</b>		23b. DATE <b>11/2/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL HOME NAME <b>Bruzdinski Funeral Home PA 1407</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 03 1987</b>		25b. REGISTRAR'S SIGNATURE 	



068086 OCT-87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Roger M. Baumgartner, Sr.			2a. DATE OF DEATH MONTH DAY YEAR October 2, 1987			2b. HOUR 10:32 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 3, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Patapasco Railroad	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Baumgartner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Hacker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-01-6776		17. INFORMANT ADDRESS Nettie J. Baumgartner same as 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Possible Aspiration</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>cardiac disease</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 9/28/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED cardiac disease		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/27/87 to 10/2/87, that (I) (we) lost saw the deceased alive on 10/2/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not know the body after death.							
22b. SIGNATURE B. Ruck				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Ruck				22e. ADDRESS SMBG H.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-6-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR OCT 06 1987		25b. REGISTRAR'S SIGNATURE Asia Terison-Pinder	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to funeral arrangements.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then register more carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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LIBRARY OF CONGRESS

AMERICAN LIBRARY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach to the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANNALETTA BAYLOR</b>			2a DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 16, 1987</b>		2b HOUR <b>7:25<sup>P</sup><sub>M</sub></b>	
3 SEX <b>FEMALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>12<sup>TH</sup> 18<sup>TH</sup> 53</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>33</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNEMPLOYED</b>		12b KIND OF BUSINESS OR INDUSTRY <b>N/A</b>				
13a STATE <b>MD</b>		13b CITY OR TOWN <b>BALTIMORE</b>		13c STREET ADDRESS / ZIP CODE <b>255 COLVIN STREET 21202</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>FRANK STREAMS</b>		15 MOTHER'S MAIDEN NAME MIDDLE LAST <b>CARRIE HAMLET</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-64-2990</b>		17 INFORMANT ADDRESS <b>FLORENCE STREAMS 255 COLVIN STREET</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intracerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>60 minutes</b> <b>8 days</b> <b>10 years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) this hospital attended the deceased from <b>10/3/87</b> , 19 <b>87</b> , to <b>10/16</b> , 19 <b>87</b> , that (1) (we) last saw the deceased alive on <b>10/16</b> , 19 <b>87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.						
22b SIGNATURE <b>Roger S. Blumenthal, M.D.</b>		DEGREE <b>M.D.</b>		22c DATE SIGNED <b>10/16/87</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Roger S. Blumenthal, M.D.</b>		22e ADDRESS <b>Johns Hopkins Hospital, 600 N. Wolfe St., Baltimore, MD 21205</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>10/22/87</b>		23c NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN CEMETERY</b>		
23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>		24 FUNERAL DIRECTOR NAME <b>WM. C. MARCH F/H 1101 E. NORTH AVENUE</b>				
25a DATE REC'D. BY REGISTRAR <b>OCT 20 1987</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>				

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OCT 30 1987

68595 OCT 14

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please make a carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

FOR  
STATE  
REGISTRAR MABEL S. BEALE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28410

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MABEL S BEALE			2a. DATE OF DEATH MONTH DAY YEAR 10 7 87		2b. HOUR 830 P						
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 01 09 13		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY HIGH SCHOOL			
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5764 STEVENS FOREST ROAD 21045			
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT SEATE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MALINDA HEDGESPEATH				ADDRESS COLUMBIA MARYLAND			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ROBERT BEALE JR. 10438 WATERFOWL TERR 21044							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Adenocarcinoma.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10.7.1987 to 10.7.1987, that (I) (we) last saw the deceased alive on 10.7.1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE Dulheil				DEGREE				22c. DATE SIGNED 10.7.87		22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) GUTHIEL				22f. ADDRESS UMCC, Balto, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/10/87		23c. NAME OF CEMETERY OR CREMATORY CHRIST EPIS. CHURCH CEM		23d. LOCATION CITY OR TOWN COUNTY STATE COLUMBIA HOWARD MARYLAND		23e. DATE REC'D. BY REGISTRAR OCT 09 1987			
24. FUNERAL DIRECTOR LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE CATONSVILLE MD 21228											

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FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2841

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM A-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles Bean

2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10/ 4/ 19 87

2b. HOUR M 12:25 a M

3. SEX M

4. RACE Negro

5. DATE OF BIRTH MONTH DAY YEAR 11 19 56

6. AGE (IN YEARS) LAST BIRTHDAY YRS. 30

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md

7b. CITIZEN OF WHAT COUNTRY? U.S. A

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD

10. CITY OR TOWN OF DEATH Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4718 Wakefield Ave.

12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) ENGINEER Insp

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE Md

13b. COUNTY

13c. CITY OR TOWN Balto

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 2032 N. Calvert St

14. FATHER'S NAME FIRST MIDDLE LAST Charles Phillip Bean Sr.

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Theresa Ercumise

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No

16b. SOCIAL SECURITY NO. 220-66-4686

17. INFORMANT ADDRESS Josephella Hamlett from 2032 N. Calvert St

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Multiple Gunshot Wounds (unspecified)  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  
(b) DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. HOUR OF INJURY A.M. MONTH DAY YEAR 2:01x 10/ 4/ 19 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) apartment at

21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4718 Wakefield Ave., Balto. City, Md.

22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 10/4/87

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation

23b. DATE 10/8/87

23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.

23d. LOCATION CITY OR TOWN COUNTY STATE Greenmount & North St

24. FUNERAL DIRECTOR NAME ADDRESS Locke Funeral Home 1304 N. Central Ave

25a. DATE REC'D BY REGISTRAR OCT - 7 1987

25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))



NOTICE

WALKER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then place this certificate in the casket with the deceased. Page 4 should be placed in the casket with the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other medical condition, a medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) PAUL O. BECKER			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 27, 1987		2b. HOUR P 9:05 AM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR August 28, 1927	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Y.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator		12b. KIND OF BUSINESS OR INDUSTRY Hospital
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN Md. Baltimore	13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13c. STREET ADDRESS / ZIP CODE 113 B Versailles Circle -04			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Lewis Becker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leora Evans			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 115 16 8421	17. INFORMANT ADDRESS Mrs. Janice Wells Quaker Rd. Collins, NY			

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal intestinal perforation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intestinal lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AIDS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>1 yr</u> <u>4 yrs.</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> 19 <u>87</u> to <u>10/27</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>10/27/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>John D. Hummel</u>	DEGREE MD	22c. DATE SIGNED 10/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Hummel		22e. ADDRESS 600 N. Wolfe St., Balt. Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/31/87	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Springville, N. Y.
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR NOV 3 1987	



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles H. Bell			2a. DATE OF DEATH MONTH DAY YEAR 10-19-87		2b. HOUR 10:18 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-24-18		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of MD Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse - Tuffin		12b. KIND OF BUSINESS OR INDUSTRY Baltimore City
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. CITY OR TOWN Baltimore	13c. STREET ADDRESS / ZIP CODE 1122 Cleveland Street 21230	
14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Bell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie M. Bury		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-05-1092		17. INFORMANT ADDRESS Lorraine M. Bell 254 Beachwood Pl. Pasadena, Ind. 47122	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c) pneumonia, urinary tract infection

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3-4 days

3-4 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

metastatic adenocarcinoma cancer of lung

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/10/87, 1987, to 10/19, 1987, that (I) (we) lost saw the deceased alive on 10/19, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Nicholas B. Argento MD		DEGREE		22c. DATE SIGNED 10/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Univ of MD Hospital 22 S. Green Street Baltimore MD 21201		22f. MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-23-1987	23c. NAME OF CEMETERY OR CREMATORY Horton Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME Philip J. Power & Son Inc. 901 Hollins St.		25a. DATE REC'D. BY REGISTRAR OCT 23 1987	25b. REGISTRAR'S SIGNATURE Lorraine M. Bell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the local registrar must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 28414			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
CORINE		P.		BELL				OCTOBER 14 1987					9:00 <sup>AM</sup>
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		BLACK		10 3 27		60		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
SC		U.S.A.				BALTIMORE CITY MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		THE JOHNS HOPKINS HOSPITAL						NURSES'S AIDE		N/A			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
MD				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		926 N. EDEN STREET 21205					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
JOHN				EDWARD				JANIE BROWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO				218-28-3574		JAMES BELL 926 N. EDEN STREET							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>												2 min	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Arrest</u>												5 min	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Breast Carcinoma</u>												7 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 9</u> , 19 <u>87</u> , to <u>Oct 14</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Oct 14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
<u>C. Lowell</u>								10/14/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
<u>C. LOWELL</u>				<u>601 N. Broadway Balto, MD.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
BURIAL				19/20/87		BALTIMORE CEMETERY		BALTIMORE,				MD	
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
WM C. MARCH F/H, INC. 1101 E. NORTH AVENUE								OCT 19 1987		<u>Lia Jordan-Landess</u>			

BP

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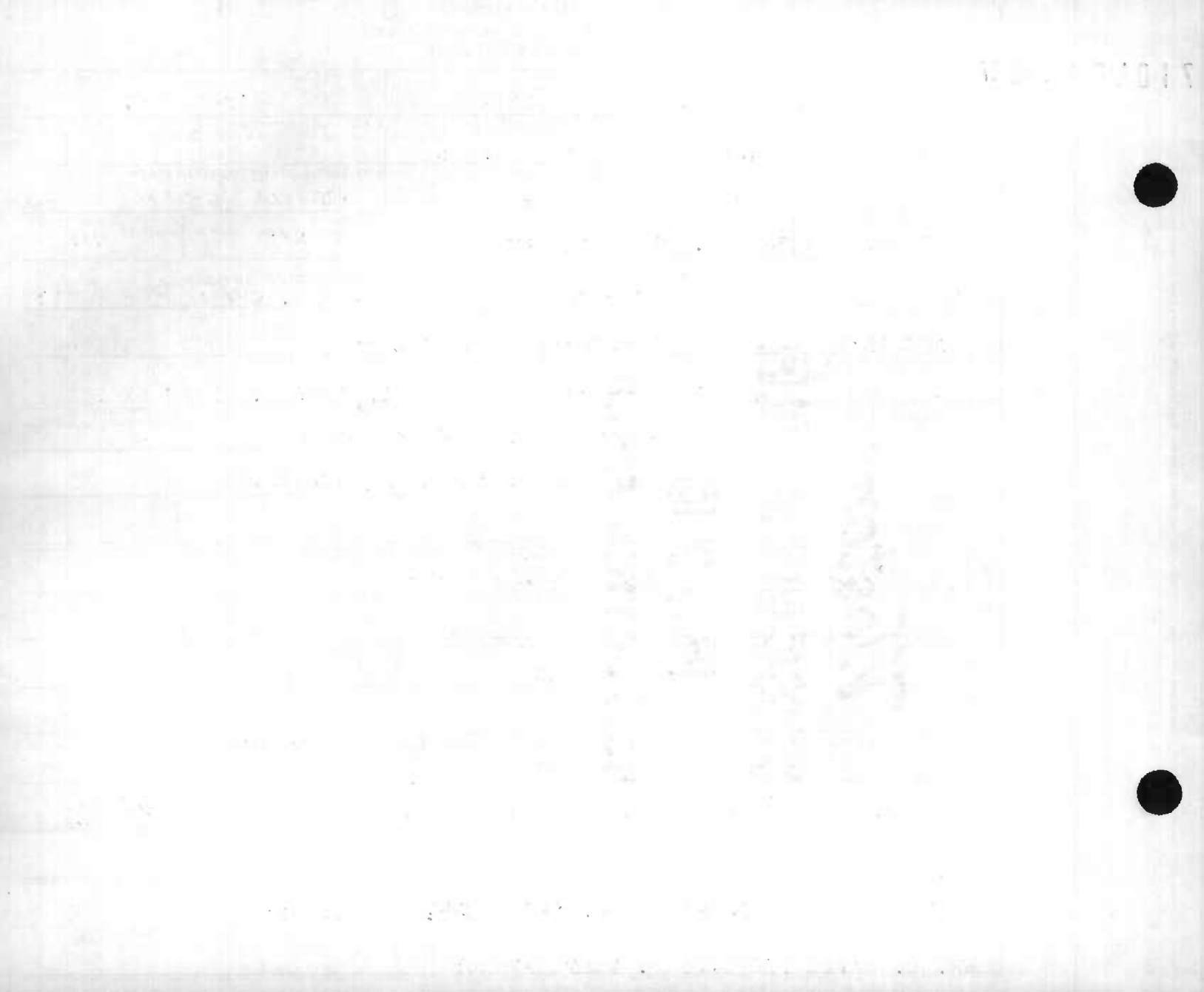


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
			LULA C. BELL			10 30 87			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		BLACK		2 14 02		85 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
NC		USA				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			2417 E. CHASE STREET			N/A			N/A		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
MD			BALTIMORE		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2417 E. CHASE STREET 21213		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
BENJAMIN CRAWFORD					ELIZABETH STATON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO					243-16-5558		A MARY BELL 2320 E. CHASE STREET				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC DYSRHYTHMIA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD / VALVULOPATHY</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CMF - CPE DTD - ANEMIA</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
			HOUR A.M. MONTH DAY YEAR P.M. 10 - 30 - 1987								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>85</u> , to _____, 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>10-30-</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE					22c. DATE SIGNED	
<u>W. C. MARCH</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					10/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
WM. C. MARCH F/H 1101 E. NORTH AVENUE											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
BURIAL			11/6/87		MD. NAT'1 PARK			LAUREL COUNTY STATE MD			
24. FUNERAL DIRECTOR					25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS					NOV 5 1987			<u>W. C. MARCH</u>			

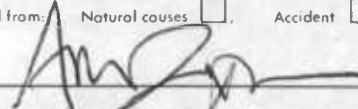
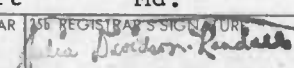




070974 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM VM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Thomas E. Bell						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-31 1987		2b. HOUR M	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6/23/57	6. AGE (IN YEARS) LAST BIRTHDAY 30 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 10-31 19 87		2d. HOUR M		2e. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2621 Springhill Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2621 Springhill Ave. 21215			
14. FATHER'S NAME FIRST MIDDLE LAST Louis Bell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margie Terry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-70-6002		17. INFORMANT ADDRESS Louis Bell 3023 Mondawmin Ave. 21216							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stabwounds of thorax</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:31 P.M. 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject stabbed							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION CITY OR TOWN COUNTY STATE 2621 Springhill Avenue, Baltimore City, MD							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 11-1-87			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn Street, Baltimore, MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/5/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Westport Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Estep Bros. F.H. 1300 Eutaw Place				25a. DATE REC'D BY REGISTRAR NOV 5 1987		25b. REGISTRAR'S SIGNATURE 					

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

[Faint, illegible text throughout the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 under any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28417

1. DECEASED NAME (TYPE OR PRINT) BESSIE M. BELLAMY			2a. DATE OF DEATH MONTH DAY YEAR 10 - 13 - 87			2b. HOUR 5 <sup>30</sup> AM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 22 12		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory worker		12b. KIND OF BUSINESS OR INDUSTRY Lever Brothers		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Brown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Taylor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-12-8827		17. INFORMANT ADDRESS Doris M. Beck 6408 Loudon Ave. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic lung carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe rheumatoid arthritis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>10/5</u> , 19 <u>87</u> , to <u>10/13</u> , 19 <u>87</u> , that (I) (we) saw the deceased alive on <u>10/13</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Melba Beine MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 10/13/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melba Beine, MD					22e. ADDRESS Mercy Hospital Baltimore MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/16/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.					25a. DATE REC'D. BY REGISTRAR 21229 OCT 14 1987		25b. REGISTRAR'S SIGNATURE Julia Swinson-Randall			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28418

1- FOR  
STATE  
REGISTRAR

68860 OCT 18 1987

DECEASED NAME (FIRST OR PRINT)		FIRST		MIDDLE		LAST		2d. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Elizabeth						Bennett		10-12		19		87				M	
1. SEX F.		4. RACE N.2		5. DATE OF BIRTH MONTH DAY YEAR 1 16 12		6. AGE (IN YEARS) LAST BIRTHDAY 75 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 10-12- 19 87				2d. HOUR 3:58P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City											
11. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 233 Silver Ct 21231									
14. FATHER'S NAME FIRST MIDDLE LAST ? ? ?		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLY BROOKS															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-30-8441		17. INFORMANT Hubert De Montegomery		ADDRESS 233 Silver Ct											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive cardiomyopathy</u> (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I have charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE Charles P. Kokes		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER										DATE SIGNED 10-13-87			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street, Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/16/87		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md.											
24. FUNERAL DIRECTOR NAME Locks Funeral Home		ADDRESS 1304 N. Central		25a. DATE REC'D. BY REGISTRAR OCT 15 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

7 8 8 8 0 1 2 6 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Oscar Clair Bennett</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>9 2 87</i>			2b. HOUR <i>9<sup>25</sup> A.M.</i>	
3. SEX <i>Male</i>		4. RACE <i>Cauc</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 2, 1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <i>88 YRS.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO CITY</i> MD.					
10. CITY OR TOWN OF DEATH <i>Balto</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Ann's Hospital of Balto</i>				12a. USUAL OCCUPATION (TYPE OR WORK, FORM OF OCCUPATION) <i>Retired Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Md</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Reisterstown</i>		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS / ZIP CODE <i>3 White Birch Ct. 21136</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry O. Bennett</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Zella M. Millen</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW 1</i>		17. INFORMANT ADDRESS <i>Mrs. Cynthia A. Bennett Reisterstown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured Abdominal Aortic Aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Exsanguination</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1a <i>Prior Myocardial Infarction</i>											
19a. DATE OF OPERATION <i>9/2/87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Hemorrhagic Shock</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I, this hospital) attended the deceased from <i>7/4/87</i> , 19____, to <i>9/2/87</i> , 19____, that (I, we) last saw the deceased alive <i>9/2/87</i> , 19____, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (us) (all) saw the body after death.											
22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) <i>Robert Breslin MD</i>				DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/2/87</i>	
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>				23b. DATE <i>Sept. 4, 87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley</i>		23d. LOCATION <i>Cockeysville, Md.</i> STATE			
24. FUNERAL DIRECTOR <i>Elaine Funeral Home Reisterstown, Md. 21136</i>						25a. DATE REC'D. BY REGISTRAR <i>SEP 03 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John A. Anderson</i>			



064811 SEP-4-87

SEP03 1987



68481 OCT 14 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) GERTRUDE A. BENSER			2a. DATE OF DEATH MONTH DAY YEAR 10 7 87			2b. HOUR 12 <sup>37</sup> P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 28 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3207 Eastern Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Laundry	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry T. Benser		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Virginia Armistead		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-09-2158	
17a. INFORMANT Mrs. Hattie Dieteman		17b. ADDRESS 3410 Dillon Street Baltimore, Md. 21224		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE ABDOMINAL PROCESS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? FEW DAYS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) H/O CONGESTIVE HEART FAILURE 2° PREVIOUS MYOCARDIAL INFARCT							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his) (hospital) attended the deceased from 19_____, to 19_____, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Christine C. Harter		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTINE C. HARTER MD		22e. ADDRESS 4940 EASTERN		BALT 21224 955-0931			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-10-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.	
24. FUNERAL DIRECTOR Ann S. Matthews, Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224				25a. DATE REC'D. BY REGISTRAR OCT 13 1987		25b. REGISTRAR'S SIGNATURE Julia S. [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove the burial/transit permit, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, or medical examiner may be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HENRY THOMAS BENSON</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>28</b> YEAR <b>87</b>		2b. HOUR <b>7:10 a.m.</b>
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>1</b> YEAR <b>11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Mineral Pigments Corp.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b></b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1600 S. Charles Street 21230</b>
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>H.</b> LAST <b>Benson</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b></b> LAST <b>Briggs</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-07-0277</b>		17. INFORMANT <b>Arthur J. Benson</b> ADDRESS <b>1913 Whistler Ave. 21230</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Ca of stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Anemia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>10/28</b> , 19 <b>87</b> , to <b>10/28</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>10/28</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Cheng Wai-Fung</b>		DEGREE		22c. DATE SIGNED <b>10/28/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHENG WAI-FUNG</b>		22e. ADDRESS <b>South Baltimore General Hosp</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10/31/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b> ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1987</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. Fisher, Registrar</b>	

MEDICAL CERTIFICATION

15-10-35-100-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna Mary Beran			2a. DATE OF DEATH MONTH DAY YEAR 10 20 87			2b. HOUR 10 <sup>25</sup> P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 6 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF SUCH PLACE IS NOT KNOWN, GIVE ADDRESS) Jenkins Memorial Home 1000 S. Caton Ave. 21229			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home Maker	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Michael Marcus				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-12-2682		17. INFORMANT ADDRESS Delaware 19958 William J. Beran 92 Water View Drive, Lewes				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable adenocarcinoma cecum</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24h	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 86 to 10-20 19 87, that (I) (we) last saw the deceased alive on 10-20 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) not see the body after death.								
22b. SIGNATURE Deborah R. Oberman DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 10-21-87		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation						23b. DATE 10/22/87		
23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Pk						23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Md		
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md						25a. DATE RECD. BY REGISTRAR OCT 23 1987		
25b. REGISTRAR'S SIGNATURE Julia D. ...								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM F. BERGER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 17, 1987</b>		2b. HOUR <b>5:30</b>		
3. SEX <b>M</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 1, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CC Seal</b>		
13a. STATE <b>Md</b>			13b. COUNTY <b>Balto</b>	13c. CITY OR TOWN <b>Balto</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Julius M. Berger</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna K. James</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Evelyn Hawk 603 S. Anne St. Apt 305</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minute</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <b>CONGESTIVE HEART FAILURE</b>	<b>1 week</b>
						(c) <b>RENAL FAILURE</b>	<b>1 week</b>
						PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>PNEUMONIA, POSSIBLE SEPSIS, ANEMIA</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 8, 1987</b> , to <b>OCTOBER 17, 1987</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 17, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Carol S. Ramsey</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CAROL S. RAMSEY, M.D.</b>				22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21230</b>			
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>		23b. DATE <b>10/20/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>John A. Moran, Inc. 3000 E. Balto. St</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1987</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18, the death was due to injury, or other traumatic event, the medical examiner must be notified *immediately*.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR										87 2342			
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARMEN L. BERTAZON										2a. DATE OF DEATH MONTH DAY YEAR October 31, 1987		2b. HOUR 10 <sup>22</sup> P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH August 20, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital						12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Builder - Self		12b. KIND OF BUSINESS OR INDUSTRY Employed			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1006 Katy Lane 21204			
14. FATHER'S NAME FIRST MIDDLE LAST William L. Bertazon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate S. Liberto									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Mrs. Virginia D. Bertazon, same as #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerotic Cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>See you</i> <i>See you</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>1983 had a aortic valve replacement.</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>3-23</i> , 19 <i>60</i> , to <i>10-31</i> , 19 <i>87</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>10-28</i> , 19 <i>87</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.													
22b. SIGNATURE <i>Alfred G. Ossman, Jr.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>11/2/87</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alfred G. Ossman, Jr., M.D.				22e. ADDRESS 1101 St. Paul St. Baltimore, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-4-87		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25. DATE REC'D BY REGISTRAR NOV 5 1987		25a. REGISTRAR'S SIGNATURE <i>Julia Borden-Randall</i>							

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Michigan  
Michigan State  
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

070717 NOV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1a. DECEASED NAME (TYPE OR PRINT) Velma E. BEST		2a. DATE OF DEATH MONTH DAY YEAR 10 26 87				2b. HOUR 4:35 P.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7 16 06		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2819 Hinsdale 21230	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 134-20-2454		17. INFORMANT ADDRESS MERCY HOSPITAL-MEDICAL RECORDS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Valvular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Lymphocytic Leukemia, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 9/25 19 87 to 10/26 19 87, that (1) we last saw the deceased alive on 10/26 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.									
22b. SIGNATURE N. W. Todd M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nevin W. Todd, M.D.				22e. ADDRESS 301 St. Paul Place Balt. MD 21202					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10-31-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME State Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR NOV 03 1987		25b. REGISTRAR'S SIGNATURE John Davidson	

70-102 515050

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

2. DECEASED NAME (TYPE OR PRINT) Marie Ann Betz			2a. DATE OF DEATH MONTH DAY YEAR October 15, 1987		2b. HOUR 1:10 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2-2-1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2830 Pelham Avenue-21213		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Digga			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Webb		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-44-0926		17. INFORMANT ADDRESS J. Morris Betz - 2830 Pelham Ave.-21213	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ca of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>years</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>did not</u> attend the decedent from above, (I) <u>did</u> attend the decedent from above, (I) <u>did not</u> view the body after death.					
22b. SIGNATURE <u>Carlos E. Arana</u>		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLOS E. ARANA, M.D.		22e. ADDRESS 3400 Erdman Ave. Balt. Md 21213			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-17-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller, Inc. 6415 Belair Rd.-21206		25a. DATE REC'D. BY REGISTRAR OCT 15 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1001100 00000

Handwritten notes, possibly a list or index, including the number 1001100. The text is faint and difficult to read.

070507 NOV-20

Item #14,17, G 633 11/19/87 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. STATE REGISTRAR		2a. DECEASED NAME (OR PRINT)		FIRST		MIDDLE		LAST		7a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		7b. HOUR	
		ANTHONY		JAMES		BEVERLY				10		28		19		87		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male		Black		Nov 24, 1964		22		MONTHS		DAYS		10		28		19		87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		U.S.A.				Baltimore City													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		Johns Hopkins Hospital		Machinist															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INDEPENDENT CITY LIMITS?		13e. STREET ADDRESS											
Maryland		BALTIMORE		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1236 E. Belvedere Ave "D"											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
James		Sally Ann Hulbert																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		218-82-2035		Sally Beverly		1236 E. Belvedere Ave													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>Hanging</u>		DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF															
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS (DO NOT RELATE TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).)		HIV antibody test positive																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
		10-28-19 87		Subject hanged self.															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION															
		police station		1620 Edison Hwy., Balto.															
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED		10-28-87									
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.		ADDRESS		111 Penn St., Balto., MD		21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION													
Burial		10-31-87		Mt. Zion Cemetery		Baltimore City, Md.													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Marshall W Jones, Jr		F.H. 4101 EDMONDSON		OCT 30 1987		Julia T. Dixon-Randall													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORMS 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Mable M Bickel</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>29</b> YEAR <b>87</b>			2b. HOUR <b>7:04 PM</b>			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>25</b> YEAR <b>1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Med Ctr</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Henry</b> MIDDLE <b>F</b> LAST <b>Bickel</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b>K</b> LAST <b>Paulus</b>			16. STREET ADDRESS / ZIP CODE <b>146 S. East Ave. 21224</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>215-50-1990</b>			17. INFORMANT <b>George C. Mertel 346 S. Bouldin St.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **No**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Urorepsis**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Clifford S. Mitchell MD</b>				DEGREE		22c. DATE SIGNED <b>10/29/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Clifford S. Mitchell</b>				22e. ADDRESS <b>FSK MC</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-2-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemet</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>City</b> STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>John A Moran Inc. 3000 E. Balto, St.</b> ADDRESS				25a. DATE RECD. BY REGISTRAR <b>OCT 30 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove so-burial papers, Pages 7 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must be notified.

10000 MW-581



WHELFMAN  
NOTES FOR

68358 OCT 14 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James F Bigwood			2a. DATE OF DEATH MONTH DAY YEAR 10/7/87		2b. HOUR 12:15 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9/02/02		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Francis Scott Key Medical Ctr		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY Balto. Co. MD	
13a. STATE MD			13b. COUNTY Baltimore	13c. CITY OR TOWN DUNDALK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST James S. Bigwood			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Honaker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 219-16-0562		17. INFORMANT ADDRESS Nellie Bigwood 3300 Cornwall Rd. 21222	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiogenic

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) Massive Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

(c) Ruptured Abdominal Aneurysm

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION 10/7/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Emergency	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 8:00 P.M. 10/7/87	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Spontaneous	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 3300 Cornwall Rd Dundalk MD	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/7/87, 19__, to 10/7/87, 19__, that (I) (we) last saw the deceased alive on 10/7/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Brett L Moses MD	DEGREE MD		22c. DATE SIGNED 10/7/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brett L Moses		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-10-87	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, MD
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk		25a. DATE REC'D. BY REGISTRAR OCT 09 1987	25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the medical examiner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, laws on any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. The first part of the report is a summary of the work done during the last year. It covers the period from January to December 1980. The summary is divided into three main sections: a general overview, a description of the work done, and a list of the results obtained. The general overview describes the progress made in the various areas of research. The description of the work done gives a more detailed account of the experiments carried out. The list of results shows the progress made in the various areas of research.

2. The second part of the report is a detailed description of the work done during the last year. It covers the period from January to December 1980. The description is divided into three main sections: a general overview, a description of the work done, and a list of the results obtained. The general overview describes the progress made in the various areas of research. The description of the work done gives a more detailed account of the experiments carried out. The list of results shows the progress made in the various areas of research.

3. The third part of the report is a list of the results obtained during the last year. It covers the period from January to December 1980. The list is divided into three main sections: a general overview, a description of the work done, and a list of the results obtained. The general overview describes the progress made in the various areas of research. The description of the work done gives a more detailed account of the experiments carried out. The list of results shows the progress made in the various areas of research.



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Respiratory Failure

10/20/87 Mountain View Hospital

10/20/87

10/20/87

10/20/87

10/20/87

10/20/87

Respiratory Failure

10/20/87



68383 OCT 14 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>VELMA M. BING</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10-12-87</b>		2b. HOUR <b>3:50 A.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 24, 1898</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Charles General Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Timonium</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lewis E. Fisher</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma C. Ellis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-54-3767</b>		17. INFORMANT ADDRESS <b>John H. Bing-4620 N. Campbell-Kansas City, Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **SEPTIC SHOCK**

DUE TO, OR AS A CONSEQUENCE OF

(b) **URINARY TRACT INFECTION**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ATHERO SCLEROTIC HEART DISEASE**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**SENIOR DEMENTIA OSTRO INTESTINAL BLEEDING**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/9, 1987</b> to <b>10/12, 1987</b> , that (I) (we) lost saw the deceased alive on <b>10/12, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/12/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. DZM</b>				22e. ADDRESS <b>North Charles Hospital Baltimore MD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-14-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc., Towson, Md. 21204</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 13 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 3.

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DATE

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NAME

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

DECEASED NAME (PRINT) <b>CATHERINE BIRD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 20 87</b>		2b. HOUR <b>7 57 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 20 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William H. Wolfgang</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sadie E. Rebuck</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>206-12-9924</b>		17. INFORMANT ADDRESS <b>Roland L. Bird 6424 O'Donnell St. 21224</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 hr.</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ANTERIOR MYOCARDIAL INFARCTION</b>					<b>24 hr.</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISEASE</b>					<b>20 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>RHEUMATOID ARTHRITIS</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>J. A. Lima</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/20/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOAO A C LIMA</b>		22e. ADDRESS <b>FRANCIS SCOTT KEY MEDICAL CENTER</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-23-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Funeral Home of Dundalk</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Swinson-Randall</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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068094 OCT 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 8 4 3 4

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anne M. Bischoff			2a. DATE OF DEATH MONTH DAY YEAR 10 3 87			2b. HOUR 4:00 P.M.		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 4 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Traffic Court		
12b. KIND OF BUSINESS OR INDUSTRY Balto. City								
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 946 E. 41st Street 21218								
14. FATHER'S NAME FIRST MIDDLE LAST August M. Detlof				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Reisinger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-38-6148		17. INFORMANT ADDRESS Mrs. Catherine B. Miller same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cadaveric Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Unseptic</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 2 hours 2 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Serious Acting Disease</u>								
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (GIVE NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>October 3, 1987</u> to <u>October 3, 1987</u> , that (I) (we) last saw the deceased alive on <u>October 3, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Wallace R. Johnson M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-3-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace R. Johnson M.D.				22e. ADDRESS Union Memorial Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/7/87		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				ADDRESS 1050 York Road		25a. DATE REC'D. BY REGISTRAR OCT 06 1987		
				25b. REGISTRAR'S SIGNATURE Julia Borden				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. It is also recommended that the funeral director remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to stationing, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

NOTICE

WITNESSES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH	
Evelyn M. Blachowicz		Female		White		August 7, 1927	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Francis Scott Key Hospital		Housewife		Own Home	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE			
Maryland		Baltimore		2365 Searles Road 21222			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	
Charles		Tillie		No		219-22-6542	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Anthony Blachowicz		2365 Searles Road		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>presumed sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>pancytopenia</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 19</u> 19 <u>87</u> , to <u>Oct 20</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Oct 20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Adelaide S. Robb MD				10/20/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Adelaide S. Robb MD		4940 Eastern Avenue Baltimore MD		Burial		10-23-87	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
St. Stanislaus		Baltimore Maryland		Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222		OCT 21 1987	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	

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100% GOLD ON PAPER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

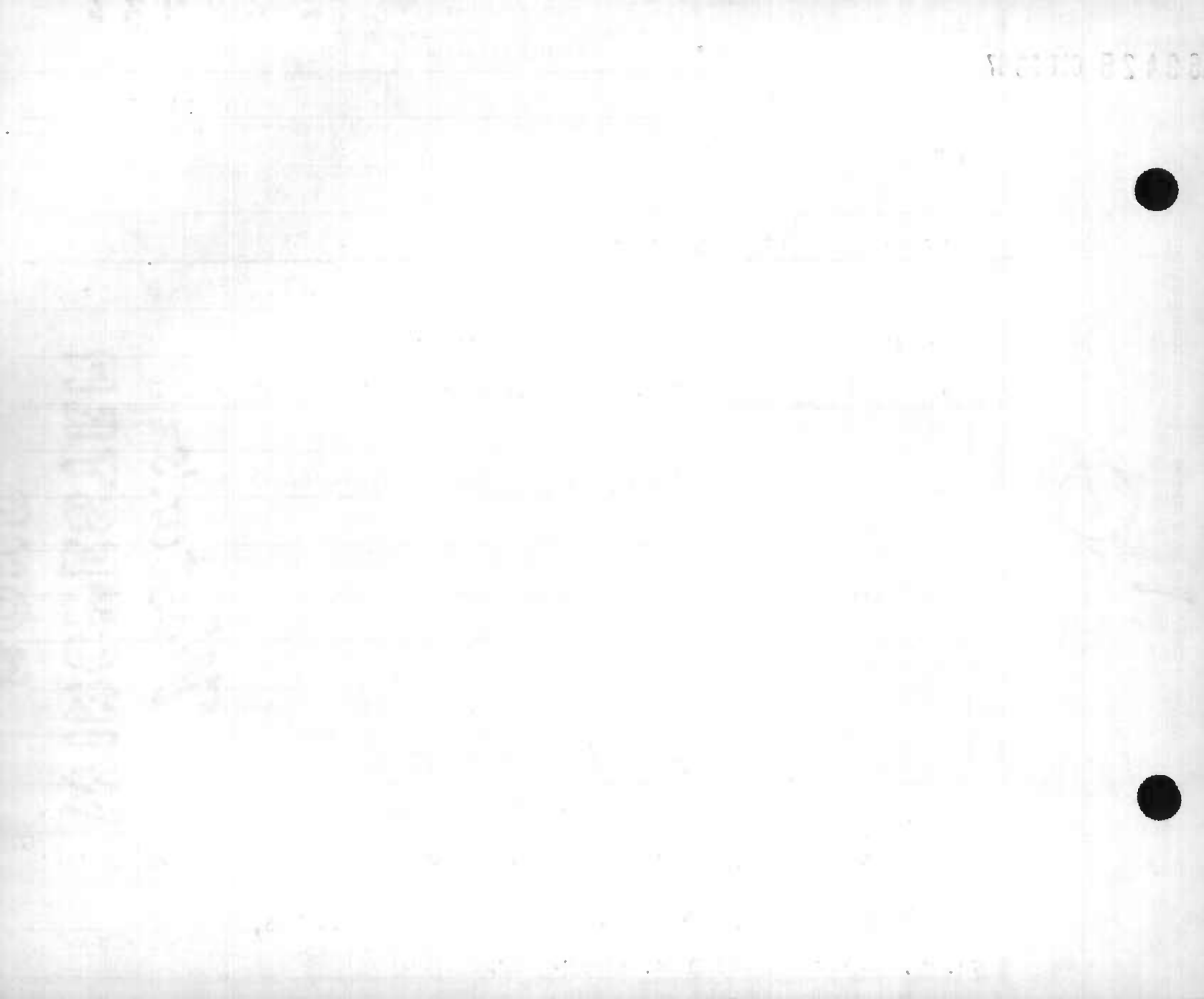
1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JESSIE C. BLAKE			2a. DATE OF DEATH MONTH DAY YEAR 10 21 87		2b. HOUR M
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 4 5 1899		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1902 HOMEWOOD AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1902 HOMEWOOD AVENUE 21218	
14. FATHER'S NAME FIRST MIDDLE LAST JESSE WIGGINS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIAH BALL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 911-36-4527		17. INFORMANT ADDRESS THELMA FLEET 3621 COTTAGE AVENUE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension cardio vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-3-87, 19 to 2-6-86, 1986, that (I) (we) last saw the deceased alive on 2-6-86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Sujo Sgarr, M.D.				22c. DATE SIGNED 10-21-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUSOTA SARRI				22e. ADDRESS 1910-14 Co. Park Street, Baltimore, MD 21223	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/24/87		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK ARBUTUS	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H 1101 E. NORTH AVENUE			
25a. DATE REC'D. BY REGISTRAR OCT 21 1987		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall			

BP





069803 OCT 27 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROSE BLATT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-22-87</b>		2b. HOUR <b>6:00 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-1-10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>AUSTRIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Levindale</b>				12a. USUAL OCCUPATION (TYPE OF WORKING LIFE) <b>HOUSEWIFE</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>COLUMBIA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALTER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LEAH UNKNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>064-09-7506</b>		17. INFORMANT ADDRESS <b>MRS. MADELINE KARPEL 8851 TIDSEBB CT. 21045</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple infected decubiti</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>weeks</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <b>10/22/87</b> to <b>10/22/87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) move the body after death.							
22b. SIGNATURE <b>S. LEVENSON</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/22/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. LEVENSON</b>		22e. ADDRESS <b>LEVINDALE</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>10/23/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW MEMORIAL PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTIMORE, MD 21215</b>				25. DATE REC'D BY REGISTRAR <b>OCT 26 1987</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event (the medical examiner must be notified at once).



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward to the appropriate authorities. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										28438	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Charles Winfred Blevins						2a. DATE OF DEATH MONTH DAY YEAR 10 1 87		2b. HOUR 10:50 PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 30 20		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of MD. hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Never Worked.		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore			
14. FATHER'S NAME FIRST MIDDLE LAST Luther Winfred Blevins						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Panthia Marie Minton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Route 3 Box 1496 Pauline Black (Sister) Fredericksburg, VA							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>5 months</u> <u>48 hours</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Metastatic Recurrent Staph aureus</u>											
19a. DATE OF OPERATION 4/21 4/24 5/21 4/30 4/5/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED coronary artery bypass graft 1 5 trach 2 Bilroth II 3 revise Bilroth II 4 wnd. dehiscence				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> , 19 <u>87</u> , to <u>OCT. 1</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>OCT. 1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>P. S. Ellison, Jr.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/2/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Strickling Ellison, Jr. MD				22e. ADDRESS 22 South Greene Street Balto 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE October 5, 1987		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Spotsylvania Co., Virginia					
24. FUNERAL DIRECTOR NAME Wheeler and Thompson Funeral Home				24b. ADDRESS 705 Princess Anne St., Fredericksburg, VA		25a. DATE REC'D. BY REGISTRAR OCT 07 1987					

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070995 NOV-87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Frieda Bliden</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 31 87</b>		2b. HOUR <b>4:22 A</b>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 5, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7203 ROCKLAND HILLS DR., APT 101 #21209</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>MEYER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MOLLIE KATAN</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>219-05-4611A</b>		17. INFORMANT <b>ABRAHAM BLIDEN</b> ADDRESS <b>7203 ROCKLAND HILL DR., APT. 101 #21209</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Irreversible shock</b> ~45 MIN DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Repair of right subclavian artery laceration</b> ~10 hrs DUE TO, OR AS A CONSEQUENCE OF: (c) <b>Attempt at placement of Hickman Catheter</b> ~30 hrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Malnutrition secondary to Long history of Crohn's disease</b>									
19a. DATE OF OPERATION <b>10/29/87</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Malnutrition</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>10/30/87</b> , 19 <b>87</b> , to <b>10/31</b> , 19 <b>87</b> , that (we) last saw the deceased alive on <b>10/31</b> , 19 <b>87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Steven Rotter</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/31/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Steven Rotter</b>			22e. ADDRESS <b>Sinai Hospital of Baltimore</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11-1-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMINO (ARLINGTON)</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>		
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Anders Runder</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO: SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
DATE: 10/1/54

Re New York letter to Bureau dated 9/24/54.  
Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.  
The LHM is being furnished to the New York Office for its information.

Very truly yours,  
[Signature]  
Special Agent in Charge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the following papers: Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

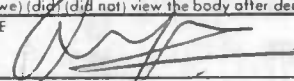
068596 OCT 1987

FOR  
STATE  
REGISTRAR

JOHN H. BLOECHER SR.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN H. BLOECHER SR.			2a. DATE OF DEATH MONTH DAY YEAR 10 8 87 2b. HOUR 7:20 P.M.		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 7/11/02	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER		12b. KIND OF BUSINESS OR INDUSTRY GROCERY
13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST HENRY BLOECHER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH REPP		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-05-5705A	17. INFORMANT ADDRESS OTTILIE BLOECHER SAME AS # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular asystole</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Renal insufficiency, left vent. failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPEY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/6/87</u> to <u>10/8/87</u> , that (I) (we) last saw the deceased alive on <u>10/8/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/8/1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NITIN MAYUR			22e. ADDRESS ST Agnes Hospital, BALTIMORE, MD.		
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 10/12/87	23c. NAME OF CEMETERY OR CREMATORY WESTERN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME ADDRESS RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228			25a. DATE REC'D. BY REGISTRAR OCT 09 1987		

1000 1000 1000 1000

68431 OCT 14 87

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
JEROME Pat BOCHESE					OCTOBER 9, 1987		11:09 <sup>A</sup> <sub>M</sub>	
1. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	Caucasian	September 8, 1930		57		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.			BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	THE JOHNS HOPKINS HOSPITAL			Driver		Warehelm Enterprises		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland	Carroll	Westminster		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1256 Carrollyn Drive 21157		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Clinton Louis Bochesse				FIRST MIDDLE LAST Sarah Diane Lamartina				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Yes Korea		213-26-2504		Mrs. Margaret Bochesse 1256 Carrollyn Drive Westminster, MD. 21157				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ruptured Abdominal Aortic Aneurysm 3 hrs</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 min</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Atherosclerosis AND ARTERIAL EMBOLIZATION</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
10/9/87		Ruptured Aneurysm			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
21g. CERTIFY THAT (I) (this hospital) attended the deceased from <u>10-1</u> , 19 <u>87</u> , to <u>10-9</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>10-9</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
William C. Doolley		MD					10/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
William C. Doolley		JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST. BALTO., MD. 21205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		10/13/87		Lake View Mem. Park		Kylesville, Carroll Maryland		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Loring Byers Funeral Directors, Inc. NAME ADDRESS 8728 Liberty Road Randallstown, MD. 21133				OCT 13 1987		Julia Davidson-Roaders		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED AS NON-MED BY DR. DENNIS SMYTH PER MARYLAND HENRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.



068559 OCT 14 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Jennie Mary BOICIUK			October 10, 1987			6:00A M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	White	November 1, 1902	84 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.				Baltimore City, MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	Gardenville Nursing Home			Seamstress			Clothing	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Baltimore			Fullerton		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
John Ziolkowski			Constance Biranowski			16b. SOCIAL SECURITY NO.		
						217-09-8425		
17. INFORMANT			18. ADDRESS			21236		
Joseph Stielper			20 Fullerton Heights Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cerebrovascular Accident</i>								2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive Anterior Circulate Vascular Disease</i>								yes
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
<i>Osteoarthritis; Alzheimer's Disease</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the <input type="checkbox"/> ) attended the deceased from <i>10/6/87</i> to <i>10/10/87</i> , that (I) (we) lost saw the deceased alive on <i>10/6/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE <i>Albert B. Bradley</i>			DEGREE M.D.			22c. DATE SIGNED <i>10/12/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert B. Bradley, M.D.			22e. ADDRESS 4900 Belair Road Baltimore, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct 12, 1987			23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		
						23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., MD.		
24. FUNERAL DIRECTOR NAME DIPPEL FUNERAL HOME, INC. 7110 Belair Road Baltimore, MD 21206			25a. DATE REC'D BY REGISTRAR OCT 13 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages, when carbon-papers, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

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OCT 13 1943

*[Faint, mostly illegible handwritten text, possibly a letter or report, with some words like "Dear" and "Yours" visible.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME

(TYPE OR PRINT)

KATHERINE ----- BOLINSKI

3. SEX

FEMALE

4. RACE

CAUCASIAN

5. DATE OF BIRTH

MONTH DAY YEAR  
6 12 92

2a. DATE OF DEATH

MONTH

DAY

YEAR

10 8 87

2b. HOUR

2 45 AM

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
UNIV. OF MD HOSPITAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)  
Confectionary

12b. KIND OF BUSINESS OR INDUSTRY

Store Opera.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

BALTIMORE

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

Md. 21230  
1228 S. Hanover St. Balto.

14. FATHER'S NAME

FIRST

MIDDLE

LAST

FRANK ----- Kunkowski

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

Glinka

Valerie -- Shtark

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17. INFORMANT

ADDRESS

Anthony Wojciechowski, Same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

888

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) CARDIAC STANDSTILL

DUE TO, OR AS A CONSEQUENCE OF

(c) RIGHT HIP FRACTUREAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

None

19a. DATE OF OPERATION

10/5/87

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

(R) HIP FRACTURE

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING ☒ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 9-19-87 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

subject apparently fell

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

kitchen

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

1228 S. Hanover St. Baltimore, Maryland

22a. I certify that (I) (this hospital) attended the deceased from 9-19, 19 87, to 10/8, 19 87, that (I) (we) last

saw the deceased alive on 10/8, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated

above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Jonathan B. Orans, MD

DEGREE

CERTIFICATION APPROVED BY PHYSICIAN

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

10/8/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

JONATHAN B. ORANS, MD

22e. ADDRESS

22 S. GREENE ST. BALTIMORE MD

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b. DATE

10/12/87

23c. NAME OF CEMETERY OR CREMATORY

Holy Rosary Cemt.

23d. LOCATION

BALTO. CO. MD.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Balto. Md. 21230

McGuilly Funeral Home, 130 E. Fort Ave.

25a. DATE REC'D. BY REGISTRAR

OCT 09 1987

25b. REGISTRAR'S SIGNATURE

John Gordon-Rodell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1881 100 27 28 3

NUMBER

1881 100 27 28 3



068691 OCT 5 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Gene Leigh Bomgardner Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 7 87</b>			2b. HOUR <b>11:03 PM</b>			
3. SEX <b>male</b>		4. RACE <b>W hite</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 20 30</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>--</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>638 Yale Avenue 21208</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Bomgardner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jean Sprinkle</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/>		16b. SOCIAL SECURITY NO. <b>182 22 9409</b>		17. INFORMANT ADDRESS <b>Charles Bomgardner 3734 Falls Rd 21211</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Ca of the Lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 5</b> , 19 <b>87</b> , to <b>OCT 7</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>OCT 7</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Michael K. Ro</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>10/7/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL K RO</b>				22e. ADDRESS <b>MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>10/09/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westview, Balto. Co., MD</b>			
24. FUNERAL DIRECTOR NAME <b>Burgee-Henss Funeral Home, P.A.</b>				ADDRESS <b>Baltimore 21211</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1987</b>		25b. REGISTRAR'S SIGNATURE <i>John T. Anderson</i>	

BP

008021 OCT 12 03



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (PRINT) FIRST MIDDLE LAST Paula L. Bonnell				Oct. 29, 1987				1:45AM	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 5/1/55		6. AGE (IN YEARS LAST BIRTHDAY) YRS 32		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1251 Frailey Way, 21205				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. STATE Maryland				13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thurman Bohrer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen A. Linster					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO --		17. INFORMANT ADDRESS 213-66-9519 Gary H. Bonnell, husband, same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BREAST CANCER</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION --		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED --				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7 19 87, to 10-29 19 87, that (I) (we) lost saw the deceased alive on 10-23 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Roy a Beverly				DEGREE MD				22c. DATE SIGNED (10-29-87)	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roy Beyridge, M.D.				22e. ADDRESS Oncology Clinic Johns Hopkins Hosp, Balto, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/31/87		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md.			
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, Balto, Md. 21213				25a. DATE REC'D. BY REGISTRAR OCT 30 1987		25b. REGISTRAR'S SIGNATURE Julia Benson-Randall			

105-101 1120

20% COTTON LINES

MADE IN U.S.A.



68194 OCT - 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NICHOLAS Matthew BOOB</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/1/87</b>		2b. HOUR <b>1:50 PM</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 2 86</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>1 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MT. WASHINGTON PEDIATRIC HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13a. STATE <b>MD.</b>				13b. CITY OR TOWN <b>WESTMINSTER</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PHILIP BOOB</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOREI Metzger BOOB</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>115-70-2726</b>		17. INFORMANT ADDRESS <b>MEDICAL CHART / MT. WASHINGTON PEDIATRIC HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory and Cardiac Arrest.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Encephalocoele</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>N/A</b>							
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>SEP. 2</b> 19 <b>87</b> to <b>OCT 1</b> 19 <b>87</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>OCT 1</b> 19 <b>87</b> , and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Martha T. Sweet</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/1/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTHA T. SWEET, MD.</b>				22e. ADDRESS <b>1834-827 LINDEN AVE. BALTO. MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>10/3/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carroll Cremation</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hampstead Carroll MD</b>	
24. FUNERAL DIRECTOR (NAME) <b>Robert K. Pritts, Sr.,</b>				412 Washington Road ADDRESS <b>Westminster, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 07 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>Robert K. Pritts, Sr.</b>							

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, or medical examination, or cause of death, must be certified by a physician.

70 C-100 101 800

68066 OCT-87

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
Howard		R.		Boren				10-2		19		87				M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Male		White		Sept 23, 1910		77 YRS.						10-2-		19		87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										2e. HOUR	
Maryland		U.S.A.				Baltimore City										8:43	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		906 W. Lombard Street.		Chauffeur		Cab Company											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Baltimore		Baltimore				906 West Lombard Street									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		WW II		217-12-6815		Susan M. Cole		Same as 13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 10-2-87													
EXAMINER'S NAME (TYPE OR PRINT)		Charles P. Kokes, M.D.		ADDRESS 111 Penn Street, Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY											
Burial		10/6/87		Maryland Veterans Cem.		Crownsville A.A. Md											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
George J. Gonce 4001 Ritchie Hgwy Balto Md		OCT 06 1987		Julia Davidson-Randall													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 8 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMM - 17  
(VR A15 ME (5))







069359 OCT

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 8 4 4 8

1. DECEASED NAME (TYPE OR PRINT) <b>VERONICA B. BOROWSKI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 18, 1987</b>			2b. HOUR M <b>AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 4, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>MARYLAND</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
12. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>438 S. ROBINSON ST.</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>438 S. ROBINSON ST 21224</b>	
17. FATHER'S NAME FIRST MIDDLE LAST <b>CLEMENT PIOTRZUSKI</b>				18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA DRENGA</b>					
19. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN (IF YES, GIVE WAR OR DATES) <b>NO</b>				20. SOCIAL SECURITY NO. <b>320 14 6219</b>		21. INFORMANT ADDRESS <b>BERNADETTE PRICE 438 S. ROBINSON ST.</b>			
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic cancer</b>  DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
23a. DATE OF OPERATION			23b. CONDITION FOR WHICH OPERATION WAS PERFORMED			24a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7-7 19 87</b>			25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
26a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			26c. LOCATION STREET CITY OR TOWN COUNTY STATE <b>600 N Wolfe St, Baltimore, MD</b>			
27a. I certify that (I) (this hospital) attended the deceased from <b>7-7</b> , 19 <b>87</b> , to <b>7-22</b> , 19 <b>87</b> that (II) (we) lost <b>9-22</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (live) (did) (did not) view the body after death.									
28. SIGNATURE <b>W. Calkins MD</b>						DEGREE		29. DATE SIGNED <b>10/20/87</b>	
30. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CALKINS</b>						31. ADDRESS <b>600 N Wolfe St, Baltimore, MD</b>			
32. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>			33. DATE <b>OCT. 21, 1987</b>		34. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEM.</b>		35. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE C. MD.</b>		
36. FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZOROWSKI</b>						ADDRESS <b>2525 FLEET ST.</b>		37. DATE REC'D BY REGISTRAR <b>OCT 21 1987</b>	
38. REGISTRAR'S SIGNATURE <b>Julia Benson-Rudolph</b>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies of pages 1 and 2 and file them with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified.

BP

CHIEF

20% POLYMER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										28449	
2. DECEASED NAME (TYPE OR PRINT) FIRST <u>Clark</u> MIDDLE <u>E.</u> LAST <u>Boston</u>										7a. DATE OF DEATH MONTH <u>10</u> DAY <u>23</u> YEAR <u>87</u>	
3. SEX <u>Male</u> 4. RACE <u>Caucasian</u> 5. DATE OF BIRTH MONTH <u>03</u> DAY <u>23</u> YEAR <u>38</u>										7b. HOUR <u>13</u> M.	
6. AGE IN YEARS LAST BIRTHDAY <u>49</u> YRS										8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>										9. BALTIMORE CITY OR COUNTY OF DEATH <u>City</u> MD.	
10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <u>SINAI HOSPITAL</u>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13b. CITY OR TOWN <u>A. A. Linthicum</u>										13c. STREET ADDRESS / ZIP CODE <u>21090</u>	
14. FATHER'S NAME FIRST <u>Francis</u> MIDDLE <u>A.</u> LAST <u>Boston</u>										15. MOTHER'S MAIDEN NAME FIRST <u>Mayetta</u> MIDDLE <u></u> LAST <u>Stuhl</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> 16b. SOCIAL SECURITY NO. <u>213-34-7584</u>										17. INFORMANT ADDRESS <u>Lynne W. Boston Same as #13</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hr.</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u></u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u>											
19a. DATE OF OPERATION <u></u> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u></u>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) <u></u>	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>10/23</u> 19 <u>87</u> to <u>10/23</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/23</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Roxanne S. Donovan MD</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										22c. DATE SIGNED <u>10/23/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Roxanne S. Donovan MD</u>										22e. ADDRESS <u></u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>										23b. DATE <u>10/27/87</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Security Process</u>										23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Balto. MD</u>	
24. FUNERAL DIRECTOR <u>301 Frederick Road 21228 MacNabb Funeral Home, Catonsville, MD</u>										25a. DATE REC'D. BY REGISTRAR <u>OCT 26 1987</u> 25b. REGISTRAR'S SIGNATURE <u></u>	

BP



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EARL Norman Bowman		2a. DATE OF DEATH MONTH DAY YEAR 10 30 87		2b. HOUR 6:15 A.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 6 08 10		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N/A Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Handler	12b. KIND OF BUSINESS OR INDUSTRY al serv. US post
13a. STATE MD		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST ERNEST J Linthicum Bowman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH A MOOG		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 216015626		17. INFORMANT ADDRESS Mrs. Jule L. Brooks Same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CHF DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE RENAL FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): ANTEROLATERAL MYOCARDIAL INFARCTION - COPD			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6 OCT 19 87, to 30 OCT 19 87, that (I) (we) last saw the deceased alive on 30 OCT 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE J. Wheeler MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 30 OCT 87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACQUELYN L. WHEELER		22e. ADDRESS 3001 SOUTH HANOVER ST	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/2/87	23c. NAME OF CEMETERY OR CREMATORY Crestlawn Mem Gdns.	23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Carroll, Md.
24. FUNERAL DIRECTOR NAME ADDRESS McGully Funeral Homes Balto., Md. 21225		25a. DATE REC'D. BY REGISTRAR NOV 3 1987	25b. REGISTRAR'S SIGNATURE Julia [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use at the burial/transit permit. Then please remove stubs (pages 3, 4, and 5) and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or yes, 18 affects any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GORMAN Franklin BOWERS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 06, 1987</b>			2b. HOUR P <b>1:25 M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 23 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Wood Finisher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cabinet Works</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Route 1 Box 90 21783</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sammuel N. Bowers</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elsie Colbert</b>				ADDRESS <b>Rt. 1 Box 90</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-09-1856</b>		17. INFORMANT ADDRESS <b>Mildred Coyle Bowers Boonsboro Maryland 21783</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>esophageal carcinoma</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b> <b>1 wk</b> <b>4 mo</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION <b>6/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Esophagectomy for Esophageal Ca</b>				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/28</b> , 19 <b>87</b> , to <b>10/6</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/6</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Paul Lin</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10/6/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL LIN</b>				22e. ADDRESS <b>600 N. Wolfe St. Pkts. Md. 21205 JOHNS HOPKINS HOSPITAL, SURGERY</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-9-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mountain View Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sharpsburg Washington Md.</b>			
24. FUNERAL DIRECTOR NAME <b>John H. Bast Jr. Boonsboro Maryland 21783</b>				ADDRESS <b>Rfd. 4 Box 7</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 09 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John H. Bast Jr.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>FLORENCE J. BOYD.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 24 87</b>		2b. HOUR <b>3:55 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 28 11</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 73 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, City</b> MD.		10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Liberty Med. Center</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-0-0-0-0-0</b>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>None</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>2728 Riggs Ave. 21216</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Johnson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-16-9520</b>		17. INFORMANT ADDRESS <b>Margaret B. Waters, 206 Denison St.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>912</b> IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>POSSIBLE ASPIRATION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE CEREBRO-VASCULAR ACCIDENT</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**URINARY TRACT INFECTION - DEMENTIA**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-21-1987</b> to <b>10-24-1987</b> , that (I) (we) last saw the deceased alive on <b>10-24-1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE		22c. DATE SIGNED <b>10-24-87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUDHIR D. PATEL</b>		22e. ADDRESS <b>BALTIMORE, MD. LIBERTY MEDICAL CENTRE</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/29/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Law Funeral Home 4611 Park Heights Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 26 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BLANCHE V. BRABHAM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 18, 1987</b>		2b. HOUR <b>8:15 AM</b>				
1. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-31-1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Baltimore City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2908 Echodale Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Woodbine</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1810 Gillis Rd. 21797</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John H. Wade</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214474-4737</b>		17. INFORMANT ADDRESS <b>Violet B. Heil 2908 Echodale Ave. 21214</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD, Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Kamal Jain</b>						DEGREE		22c. DATE SIGNED <b>10/20/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kamal Jain, M.D.</b>						22e. ADDRESS <b>101 W. Bidgley Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10-21-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>						ADDRESS <b>Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>OCT 21 1987</b>	

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OCT 21 87

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Margaret C. Brady</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-14-1987</b>			2b. HOUR <b>12 Noon</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-26-1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2808 Gibbons Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2808 Gibbons Ave. 21214</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John T. Brady</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret E. Doherty</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-10-3179</b>		17. INFORMANT ADDRESS <b>Margaret A. Rew, Same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Arteriosclerotic Cardiovascular disease Cj PP</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Gracito Patricio, M.D.</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/15/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gracito Patricio, M.D.</b>						22e. ADDRESS <b>2926 E. Cold Spring La.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10-16-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>			23d. LOCATION (CITY OR TOWN COUNTY STATE) <b>Balto., Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 16 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director. Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other injury or condition, the medical examiner must be notified at 403-6000.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) <b>ROBERT</b>			FIRST MIDDLE LAST <b>BRANCH Sr.</b>			2a DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 15, 1987</b>			2b HOUR <b>9:30 P.M.</b>		
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>6 11 11</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>			12b KIND OF BUSINESS OR INDUSTRY <b>BAKER</b>		
13a STATE <b>MD</b>		13b COUNTY <b>BALTO.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c STREET ADDRESS / ZIP CODE <b>1835 N. BOND STREET 21213</b>					
14 FATHER'S NAME FIRST MIDDLE LAST <b>MITCHELL</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>WILLIE</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b SOCIAL SECURITY NO. <b>N/A</b>		17 INFORMANT ADDRESS <b>ROBERT BRANCH JR. 5625 PURDIE AVENUE</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Overwhelming Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>16 hours</b> <b>16 hours</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Status Post Cerebellar Hemorrhage</u>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Status Post Cerebellar Hemorrhage</u>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>10/3</u> , 19 <u>87</u> , to <u>10/15</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Edward Goldstein</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>10/15/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edward Goldstein</u>				22e. ADDRESS <u>Johns Hopkins Hospital</u> <b>600 N WOLFE ST BALTO MD 21205</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/20/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MD</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 19 1987</b>		25b. REGISTRAR'S SIGNATURE <u>Julia Jordan-Randall</u>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS S. BRANICK, JR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 28 87</b>			2b. HOUR <b>12:40 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 15 30</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ. of MD.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SSA</b>		
13a. STATE <b>MD.</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6901 Springhill Dr. 21784</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis S. Branick, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marian McCall</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-28-7355</b>		17. INFORMANT <b>Mrs. Carole Branick</b> ADDRESS <b>21784</b> <b>6901 Springhill Drive Sykesville, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Squamous cell carcinoma of esophagus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cirrhosis of Liver</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>2 yrs.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from <b>9/25</b> 19 <b>87</b> , to <b>9/28</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>9/28</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)										
22b. SIGNATURE <b>Peter Cenehan M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9/28/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Peter Cenehan M.D.</b>			22e. ADDRESS <b>22 S. Groene St, Baltimore, md 21022.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/02/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Carroll MD.</b>			
24. FUNERAL DIRECTOR <b>Loring Byers Funeral Directors, Inc.</b> NAME ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 2 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and signed.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARAH M. BRAUN			2a. DATE OF DEATH MONTH DAY YEAR 10 22 87			2b. HOUR 10:10 PM	
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 09 27		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2226 Eagle Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. STREET ADDRESS / ZIP CODE 2226 EAGLE ST. BALTO, MD 21223	
14 FATHER'S NAME FIRST MIDDLE LAST VINCENT CORUZZI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY Destefeno			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-20-9398		17 INFORMANT ADDRESS Ottavis Coruzzi 3915 Wilkens Ave. 21229			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUDDEN CARDIAC DEATH DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD - CORONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) INFERIOR MYOCARDIAL INFARCTION							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 3 YEARS 3 YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 10-15-87 to 10-23-87, that (I) (we) saw the deceased alive on 10-15-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Oscar E. Fernandini M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-23-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSCAR E. FERNANDINI MD				22e. ADDRESS 5550 Baltimore National Pike BALTO, MD 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/26/87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR OCT 26 1987		25b. REGISTRAR'S SIGNATURE Dorothy R. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The physician certifying the death certificate must be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OFFICE RECORDS

SUBJECT: DEATH

RECORDS SECTION

10-27-61

10-27-61

10-27-61

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST HAROLD A. BRIGHTFUL, Sr.			MONTH DAY YEAR 10 20 87			M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Black	MONTH DAY YEAR 6 23 40		47 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.	USA			Baltimore City MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Balto.	6101 LOCH RAVEN			Sec. Guard		C&P Telephone		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE			
13a. STATE Md.			13b. COUNTY Balto.		13c. STREET ADDRESS / ZIP CODE 6101 Loch Raven Blvd. 21239			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Steve Harris			Odella Brightful					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No			218-36-7079		Carmen Brightful 7914 Dunhill Village Cir			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER of pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/29/87</u> , 19 <u>87</u> , to <u>10/21/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/21/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Maureen Kogel</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/21/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			10/21/87		New Cathedral Cem.		Baltimore, Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
WM. C. MARCH F/H 4300 WABASH AVENUE				OCT 23 1987		<u>Maureen Kogel</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Item 18a, 20, 21a, b, c, d, e, f, 22a G632 dw STATE OF MARYLAND  
 1- FOR 10-30-87 per med exam DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 REGISTRAR  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. 28459

069294 OCT 20 1987

1- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**DIANE FAY BRINK**

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 10-14-87 2b HOUR M  
 3 SEX Female 4 RACE White 5 DATE OF BIRTH MONTH DAY YEAR Feb. 17, 1946 6 AGE (IN YEARS) 41 7c. DATE PRONOUNCED DEAD 10-14-87 8:20 PM  
 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD  
 10 CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 228 Stonecroft Apt. H 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LPN 12b KIND OF BUSINESS OR INDUSTRY Nursing  
 13a STATE Md. 13b COUNTY Balto. 13c CITY OR TOWN Baltimore 13d INSIDE CITY LIMITS? YES ☐ NO ☒ 13e STREET ADDRESS 21228 228 Stonecroft Rd. Apt. H  
 14 FATHER'S NAME FIRST MIDDLE LAST Andrew Kowalick 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Brown  
 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 578-64-2077 17 INFORMANT 3625 Majestic Lane Andrew Kowalick Bowie, Md. 20715

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) Amitriptyline intoxication  
 DUE TO, OR AS A CONSEQUENCE OF  
 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  
 (b) \_\_\_\_\_  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c) \_\_\_\_\_  
 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10 19 87 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Ingestion of drugs  
 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) above residence 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 22u Stonecroft Baltimore City, MO.  
 22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐.  
 ACTUAL SIGNATURE Margarita A. Korell M.D. Assistant MEDICAL EXAMINER DATE SIGNED 10-15-87  
 EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street  
 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation 23b. DATE Oct. 19, 1987 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.  
 24. FUNERAL DIRECTOR NAME ADDRESS H. J. Schmitt Owings Mills, Md. 25a. DATE REC'D BY REGISTRAR OCT 20 1987 25b. REGISTRAR'S SIGNATURE John Davidson

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 BP 827 DHMH - 17 (VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM B. BRISBOIS				2a. DATE OF DEATH MONTH DAY YEAR 10 21 87				2b. HOUR 2 35 M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 22 13		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPPLY SPECIALIST		12b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 417 WHEATON PLACE APT B 21228			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM THEODORE BRISBOIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE CORDEALIA ALLEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-03-1593A		17. INFORMANT ADDRESS ESTHER BRISBOIS 417 b WHEATON PLACE 21228							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 DAY	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain Metastasis - Central E. Area</u>										unknown	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Brain Tumor base like prostate</u>										unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Macro Nodule Pineal</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <u>10/10</u> , 19 <u>87</u> , to <u>10/21</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Cliff Ratliff, Jr.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/21/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CLIFF RATLIFF, JR.				22e. ADDRESS 5772 WESTVIEW MALL CATONSVILLE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 10/21/87		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR NAME LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228						25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 22 1987					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic cause, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
Clara				BRISCO	10 107 187	M
3 SEX	7	4 RACE	Black	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
				10/017-01	85 86 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
7a Md.	7b USA			Baltimore City MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Baltimore	Lmc 2600 hwy 1st					
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE		
Md.		Baeso		140 W. Lafayette Ave 21211		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		17. INFORMANT ADDRESS		
Unkn		Unkn		Nigel Brumby - Baeso, Md		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
				Nigel Brumby - Baeso, Md		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Aspiration pneumonia						3-4 days
DUE TO, OR AS A CONSEQUENCE OF (b) C.H.F.						Yrs.
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
		P.M. 19				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (his) (her) (their) attended the deceased from 2/2 19 75 to 10/6 19 87, that (I) (we) lost saw the deceased alive on 10/06 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE		DEGREE		22c DATE SIGNED		
Doratan N Naem		MD		10/7/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS				
AMATUN N. NAEEM		501 Dolphin St Balto MD 21211				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE
BURIAL		10-9-87		Mt. Zion		Baltimore MD
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE
Nancy Urellane		3405 W. Franklin St		OCT 13 1987		Nancy Urellane

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please transfer carbon papers. Page 1 (which should be retained in 24 hours after death) with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR Item #12a Film G632

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- STATE REGISTRAR per funeral home 10-26-87 fs

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>James O. Britt</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Tues 10 20 1987</b>		2b. HOUR <b>11:05A</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 6 1920</b>	6. AGE [IN YEARS LAST BIRTHDAY] <b>67</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ. of Maryland Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Steel Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY <b>Balto</b>	13c. CITY OR TOWN <b>Balto</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS & ZIP CODE <b>2936 Ellicott Dr. 21216</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Cheatham Britt</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leola Mitchell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW II 223 18 1377</b>		17. INFORMANT ADDRESS <b>MRS. VANESSA COLEMAN 4115 FORDLEIGH RD.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiorespiratory Arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Esophageal cancer**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>October 16</b> , 19 <b>87</b> , to <b>Oct 20</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>Oct 20</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Thomas Sweet</b>	DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/20/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas Sweet</b>		22e. ADDRESS <b>22 South Greene St.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>10/24/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GARRISON FOREST VET CEM</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>OWINGS MILLS (BALTO.) MD.</b>
24. FUNERAL DIRECTOR NAME <b>LEWIS T. GWYNN</b> ADDRESS <b>4517 PARK HEIGHTS AVE. 21215</b>		25a. DATE REC'D BY REGISTRAR <b>OCT 23 1987</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Gordon-Randall</b>

BP







068119 OCT 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Arthur R. Brooks</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 1 '87</b>		2b. HOUR <b>9:44 AM</b>	
3. SEX <b>M</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 29 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BRICK MASON</b>	
13a. STATE <b>md</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>FORACER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HEATH Thompson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-01-1699</b>		17. INFORMANT ADDRESS <b>BERTHA N. PARKER 2120 PEN ROSE AVE</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO - PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASPIRATION PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>CVA</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Thomas S. Miller</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/1/87</b>
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS S. MILLER, MD</b>				23b. ADDRESS <b>BON SECOURS HOSPITAL</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/6/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus md</b>
24. FUNERAL DIRECTOR NAME <b>CHATMAN-HARRIS FH 1701 McGILLOP ST</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 8 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia...</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1. The first of the three  
 is the one which is  
 the most common of the  
 three. It is the one which  
 is the most common of the  
 three.

2. The second of the three  
 is the one which is the  
 most common of the three.

3. The third of the three  
 is the one which is the  
 most common of the three.

4. The fourth of the three  
 is the one which is the  
 most common of the three.

5. The fifth of the three  
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6. The sixth of the three  
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 most common of the three.

9. The ninth of the three  
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 most common of the three.

10. The tenth of the three  
 is the one which is the  
 most common of the three.

11. The eleventh of the three  
 is the one which is the  
 most common of the three.

12. The twelfth of the three  
 is the one which is the  
 most common of the three.

13. The thirteenth of the three  
 is the one which is the  
 most common of the three.

14. The fourteenth of the three  
 is the one which is the  
 most common of the three.

15. The fifteenth of the three  
 is the one which is the  
 most common of the three.

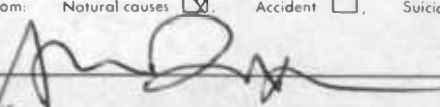
16. The sixteenth of the three  
 is the one which is the  
 most common of the three.

070798 NOV 14 1987

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Hilton			MIDDLE M.			LAST Brooks			2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 10		DAY 30		YEAR 1987		2b. HOUR M	
3. SEX male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 1-7-26		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-30 19 87		2d. HOUR A M 1:30							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City									
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saint Agnes Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Halethorpe				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 21227 193 N.E. Ave. Halethorpe Md.					
14. FATHER'S NAME FIRST MIDDLE LAST John F. Brooks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES Dotson																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW II 219-10-8617				17. INFORMANT ADDRESS Mrs Frances Brooks 1931 N.E. Ave 21227													
CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure disorder</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Throat Cancer																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy Chief				MEDICAL EXAMINER				DATE SIGNED 10-31-87									
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn Street, Baltimore, MD 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-4-87				23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST V.A.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md									
24. FUNERAL DIRECTOR NAME JOSEPH L. RUSSELL				ADDRESS 2222 W. NORTH AVE				25a. DATE REC'D. BY REGISTRAR NOV 03 1987				25b. REGISTRAR'S SIGNATURE Julia Denson-Rudner									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84  
25M

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))



069916 OCT 27 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 7 2 8 4 6 9

FOR STATE REGISTRAR			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH P. BROOKS</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>21</b> YEAR <b>87</b> 2b. HOUR <b>10:45</b> <sup>P</sup>		
3. SEX <b>M</b>	4. RACE <b>B V</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>16</b> YEAR <b>10</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.		10. CITY OR TOWN OF DEATH <b>Baltimore</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Liberty Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>NA</b> MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST <b>NA</b> MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-03-9875</b>		17. INFORMANT <b>Frances M. Brooks</b> ADDRESS <b>2405 Francis St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>UPPER GI BLEEDING</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATRIAL FIB</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CEREBRAL THROMBOSIS, CARDIAC ARRHYTHMIA, PERM. PACEMAKER</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/20/87</b> to <b>10/21/87</b> , that (I) (we) last saw the deceased alive on <b>10/21/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Woreta</b> MD		22c. DATE SIGNED <b>10/21/87</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AMBACHEW WORETA</b>	
22e. ADDRESS <b>LIBERTY MEDICAL CENTER, BALTO</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			
23b. DATE <b>10/26/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem.</b>		23d. LOCATION CITY OR TOWN <b>Lansdown, Md.</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H West</b> ADDRESS <b>4300 Wabash Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 26 1987</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Their please remove carbon copy of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR NURSING REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Mildred BROOKS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>October 13, 1987</b>			2b. HOUR <b>10:58<sup>P</sup><sub>M</sub></b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1/15/1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO., MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1402 ODESSA THOMAS CT. 21205</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM BRANCH</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESTELLE YOUNG</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214 20 9701</b>		17. INFORMANT ADDRESS <b>DANIEL G. BROOKS 1402 ODESSA THOMAS CT.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes; Hypertension; Poor compliance</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <b>Congestive heart failure</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 10, 19 87</b> , to <b>October 13, 19 87</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 13, 19 87</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Harry M. Harris</b> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harry Harris, M.D.</b>					22e. ADDRESS <b>c/o Maryland General Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10/17/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO., MD.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>LEROY O. DYETT 4600 LIBERTY HEIGHTS</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 15 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rudner</b>		

UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C. 20250

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or letter containing several paragraphs of text, possibly including a list or table. Some words like "information", "report", and "attached" are faintly visible.]





067779 OCT -7 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Brough, John R.			2a. DATE OF DEATH MONTH DAY YEAR 10 3 87			2b. HOUR 7:32 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9 19 14		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4404 Colmar Gardens Road Apt D				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker	
12b. KIND OF BUSINESS OR INDUSTRY Baking							

13a. STATE Md			13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4404 Colmar Gardens 21211		
14. FATHER'S NAME FIRST MIDDLE LAST John Howard Brough						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie V. Brooks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Randallistown, Maryland Franklin Brough 3906 Susanna Rd. 21133					

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } Squamous Cell Cancer Lung								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 months	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/11 1986 to 10/3 1987, that (I) (we) last saw the deceased alive on 10/2 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Renée J. Hyatt MD				DEGREE		22c. DATE SIGNED 10/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RENEE J. HYATT				22e. ADDRESS Loch Raven Veterans Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/06/87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Co. Md.	
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24. FUNERAL DIRECTOR NAME ADDRESS Burgee-Henss Funeral Home 3631 Falls Road 21211		25a. DATE REC'D. BY REGISTRAR OCT 6 1987		25b. REGISTRAR'S SIGNATURE John H. Rodgers	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



068809 OCT 16 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BERTHA BROWN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 9, 1987</b>		2b. HOUR <b>7 A.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 25, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		
7a. BIRTH PLACE (COUNTRY) <b>LITHUANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6807 PARK HTS. AVE., APT. 1H (21215)</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL BLOOM</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>TILLIE UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-36-7602</b>		17. INFORMANT ADDRESS <b>GILDA SHERMAN 8018 MELODY LANE 21208</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Adenocarcinoma of the Colon</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Barry S. Gold MD PA.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/9/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY S. GOLD MD. PA.</b>				22e. ADDRESS <b>122 SLADE AVE Suite 301 Balto, Md 21208</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/11/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PETACH TIKVAH CEM</b>		23d. LOCATION <b>ROSEDALE BALTO COUNTY MD</b> STATE		
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 15 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The purpose of this document is to provide information on the status of the project.

2. The project is currently in the planning stage and is expected to be completed by the end of the year.

3. The project is being funded by the Department of Defense and is being managed by the Office of the Secretary of Defense.

4. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

5. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

6. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

7. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

8. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

9. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

10. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

11. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

12. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

13. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

14. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

15. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

16. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

17. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

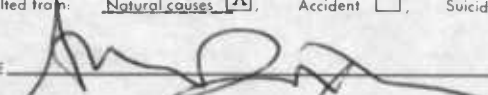
18. The project is being implemented in a phased manner and is expected to be completed by the end of the year.

068800 OCT 15 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28467

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ethel Brown</b>				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10/ 11/ 87				2b. HOUR 1:35 P M	
3. SEX <b>F</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 31 1898</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>89 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10/ 11/ 19 87</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pine Bluff, Ark.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3333 Virginia Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3333 Virginia Ave. 21215</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>136-24-5141</b>		17. INFORMANT <b>Cletia Jackson</b>		ADDRESS <b>3333 Virginia Ave. 21215</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>10/12/87</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>10-17-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Jas. A. Morton &amp; Sons 1701 Laurens</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 15 1987</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A) 5 ME (5)

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OCT 19 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The certificate remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) HARMON		FIRST BROWN		MIDDLE BROWN		LAST BROWN		2a. DATE OF DEATH MONTH DAY YEAR 10 13 1987		2b. HOUR 5A M	
3. SEX M		4. RACE B 2		5. DATE OF BIRTH MONTH DAY YEAR 12 17 31		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MOUNT CHARLES HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 601 WYANOKE AVENUE 21218			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISY RICHARDSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-28-4893A		17. INFORMANT ADDRESS Ann Brown 601 Wyanoke Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 4 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1987, to 10/13/87, that (I) (we) last saw the deceased alive on 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Laurie H. Harris				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/13/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Laurie H. Harris				22e. ADDRESS MOUNT CHARLES HOSP							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/17/87		23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE LANDSDOWNE, MD					
24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE						25a. DATE REC'D. BY REGISTRAR OCT 16 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudman			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Helen Coker Brown</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Oct 30 87</i>		2b. HOUR <i>10:40 PM</i>	
3. SEX <i>F</i>		4. RACE <i>B L</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 22 1922</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Univ. of Maryland</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housekeeper</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>
13a. STATE <i>Md.</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>James Coker</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Seretta Coker</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>216-244115</i>
17. INFORMANT ADDRESS <i>Silver Spring, Md. Francis Galbway 4501 Danland Rd.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pancreatic Cancer.</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 30</i> , 19 <i>87</i> , to <i>Oct 30</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>Oct 30</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Fw. Martinez</i>		DEGREE		22c. DATE SIGNED <i>10/30/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Francisco Martinez</i>		22e. ADDRESS <i>Univ of Md Hospital</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11-3-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King Mem PK.</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balt Md.</i>						
24. FUNERAL DIRECTOR NAME <i>James A. Morton + Sons</i>		ADDRESS <i>1701 Laurens</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 03 1987</i>		
		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

BP. \_\_\_\_\_

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

069712 OCT 26 1987

DECEASED NAME (Type or Print) <b>IRENE E. BROWN</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>19</b> YEAR <b>87</b>		2b. HOUR <b>M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>25</b> YEAR <b>14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>705 DEACON HILL COURT</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MAINTENANCE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>METROPOLITAN</b>
13a. STATE <b>MD</b>	13b. COUNTY <b></b>	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>705 DEACONHILL COURT 21225</b>	
14. FATHER'S NAME FIRST <b>GEORGE</b> MIDDLE <b></b> LAST <b>HENDRICKS</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ELIZABETH</b> MIDDLE <b></b> LAST <b>BENNETT</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/> IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-18-1148</b>		17. INFORMANT ADDRESS <b>FORESTINE BROWN 705 DEACON HILL COURT</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Codexia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bowel obstruction</b>	<b>2 mo</b>
	DUE TO, OR AS A CONSEQUENCE OF (c) <b>Crown Ca</b>	<b>6 mo</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/2</b> 19 <b>87</b> , to <b>10/19</b> 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>10/11</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>William C. Waterfield</b>	DEGREE <b>MD</b>	22c. DATE SIGNED <b>10/19/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.C. Waterfield</b>		22e. ADDRESS <b>St Agnes Hospital 900 Canton Ave Balt Md 21229</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>10/24/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>ANNE ARUNDEL CO., MD</b>
24. FUNERAL DIRECTOR NAME <b>WM. C. MARCH F/H 1101 E. NORTH AVENUE</b> ADDRESS <b>BCT 23 1987</b>		25. DATE RECEIVED BY REGISTRAR <b>10/23/87</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPHINE J. BROWN</b>						2a. DATE OF DEATH MONTH <b>10</b> DAY <b>2</b> YEAR <b>1987</b>		2b. HOUR <b>M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>19</b> YEAR <b>1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>722 WHITMORE AVENUE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RECREATION DIRECTOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. CITY</b>	
13a. STATE <b>MARYLAND</b>						13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST <b>CHARLES</b> MIDDLE <b>JOHNSON</b> LAST <b>JOHNSON</b>						15. MOTHER'S MAIDEN NAME FIRST <b>DORIS</b> MIDDLE <b>HILL</b> LAST <b>HILL</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO.</b>		16b. SOCIAL SECURITY NO. <b>220-22-8994</b>		17. INFORMANT <b>MR. LEWIS J. BROWN, JR.</b>		ADDRESS <b>BALTO. MD. 21216</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pancreatic Cancer</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 6</b> , 19 <b>87</b> , to <b>Sept 9</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>Sept. 11</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Walter M. Morgan III</b>		DEGREE				22c. DATE SIGNED <b>10-6-87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Walter M. Morgan III</b>		22e. ADDRESS <b>Johns Hopkins Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/7/1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>		23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>MD.</b>			
24. FUNERAL DIRECTOR NAME <b>WALTER FUNERAL HOME, INC.</b> ADDRESS <b>2501 GWYNNS FALLS PKWY, BALTIMORE, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 07 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>KINSEY N. BROWN</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>10 9 19 87</b>		2b. HOUR M <b>3P</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 11 83</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>4 YRS</b>		7. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10 9 19 87</b>		7b. HOUR M <b>3P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Harford</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS <b>48 East Bel Air Ave. #10</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leon M. Brown</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Brenda Anita Myers</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>N/A</b>			17. INFORMANT ADDRESS <b>Brenda A. Myers, SAME AS ABOVE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Head injuries with complications</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:56xx 10-5- 19 87</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Passenger of auto/motor vehicles collision.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Pulaski Hwy. &amp; Oakington Rd., Harford, MD</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i>			TITLE (SPECIFY) <b>Assistant</b>			MEDICAL EXAMINER			DATE SIGNED <b>10-10-87</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Mario F. Golle, Jr., M.D.</b>			ADDRESS <b>111 PennSt., Balto., MD 21201</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/14/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harford Mem. Gardens</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aberdeen Harford Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399</b>			25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1987</b>			25b. REGISTRAR'S SIGNATURE <i>Julia Burden-Roth</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

009150 OCT 12 1961

20% COTTON FIBER

WATERPROOF


100% P. 1 T30



068644 OCT 15 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										28472	
FOR 1- STATE REGISTRAR										REG. NO.	
DECEASED NAME FIRST MIDDLE LAST Leon Brown										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10/12/19 87	
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 12 12 1931		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 55		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10/12/19 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa				7b. CITIZEN OF WHAT COUNTRY? U S A				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1202 Braddish Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1202 Braddish Avenue 21216			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Grant					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Brown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes				16b. SOCIAL SECURITY NO. 213-14-5976		17. INFORMANT Elsie Farmer		ADDRESS 1202 Braddish Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? ABDO. ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy Chief				MEDICAL EXAMINER DATE SIGNED 10/12/87			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/16/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue						25a. DATE REC'D BY REGISTRAR OCT 14 1987					

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

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*Handwritten signature or initials.*

008044 OCT 12 21

68606 OCT 15 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mabel V. Brown</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-9-87</b>			2b. HOUR <b>M</b>			
3. SEX <b>Female</b>		4. RACE <b>Col</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-3-10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2115 Clifton Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Boyce</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Barnes</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>213 32-796</b>			17. INFORMANT ADDRESS <b>Mr. William Brown 2115 Clifton Ave. 21217</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ovarian cancer.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal failure</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <b>9/15/82</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Renal failure</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2435 W. Belvedere Ave; Balto; MD</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>9/15/82</b> , 19 <b>10/8</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Milan Wister</b>			DEGREE <b>PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>10/13/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MILAN WISTER</b>			22e. ADDRESS <b>2435 W. Belvedere Ave; Balto; MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10-13-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. C. MD</b>		
24. FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b>			ADDRESS <b>2222 W. North Ave</b>			25a. DATE REC'D BY REGISTRAR <b>OCT 14 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Tidman-Randall</b>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The state remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for registration, certification, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



071045 NOV

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2b. DATE OF DEATH		MONTH DAY YEAR		2c. HOUR	
		Roscoe		Bruce		10		29		87	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Black		3/4/10		77		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA				Baltimore				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Northwest M.H.		RETIRED		MECHANIC					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		401 E 28th Street		21218	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
MOSES AUGUSTUS BRUCE		ANNIE MYRIA WATERS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
NO		220-05-7834		MRS. SHIRLEY B. LOCKETT		3222		YOSEMITE AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		M.50 Cardiac infarct		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		4-6 wks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		Atherosclerotic Cardio Vasc. dis.		(4 yrs.)					
		DUE TO, OR AS A CONSEQUENCE OF									
		(c)									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Carcinoma of the lung terminal									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET							
22a. I certify that (I) (this hospital) attended the deceased from		9-1		19-87		to 10/29		1987		that (I) (we) last	
saw the deceased alive on		10/18		19-87		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
Amatun H. Naem		MD		10/29/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
AMATUN H. NAEM		501 Dolphin Street, Balto, MD		21217							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
BURIAL		11/3/87		ST. THOMAS CEMETERY		RANDALLSTOWN		(BALTO.)		MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME		4517 PARK HEIGHTS AVE.		NOV 04 1987		Julia Gordon-Randall					
GWYN											

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) <b>SALVATORE BUCCHERI.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10-29-87</b>		2b. HOUR MIN. <b>8:35</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 1 1906</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>81 yrs.</b>	IF UNDER 1 YEAR MONTHS DAYS <b>- -</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN HOSPITAL</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffeur</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>	13b. COUNTY	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2006 BURNWOOD RD 21239</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nicholas Buccheri</b>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mariana unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-09-8587</b>	17. INFORMANT ADDRESS <b>Mrs. Camilla Buccheri same as 13e</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <b>MASSIVE MYOCARDIAL INFARCT</b>		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a			
19a. DATE OF OPERATION <b>-</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>- - - 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>	
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>- - - - -</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/1/87</b> 19 <b>87</b> to <b>10/29</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/24</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>[Signature]</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>10/29/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BASSAM ATIKEN</b>	22e. ADDRESS <b>13025 COLBERT RD - BALTO, MD 21239</b>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/02/1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>		25a. DATE RECEIVED BY REGISTRAR <b>NOV 03 1987</b>	

REGISTRAR'S SIGNATURE  
**[Signature]**



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069678 OCT 28 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <b>Howard</b> MIDDLE <b>Joseph</b> LAST <b>Buckingham</b> <b>HOWARD JOSEPH BUCKINGHAM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 21 87</b>			2b. HOUR <b>7:05</b> M				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 24, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Med Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Postal Service</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. CITY OR TOWN <b>Baltimore</b>		13c. STREET ADDRESS / ZIP CODE <b>1000 Franklin Ave. Apt. 208</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Buckingham</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanor Gallagher</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>213 14 0985</b>		17. INFORMANT ADDRESS <b>Florence Buckingham Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPUL ARREST</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MYO CARDIOGENIC EMBOLI</b>										
(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9 17</b> , 19 <b>87</b> , to <b>10 21</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10 21</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>10 21 87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEFF</b>			22e. ADDRESS <b>FSD MC</b>							
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>			23b. DATE <b>Oct. 26, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Mem. Gard.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Maryland</b>			
24. FUNERAL DIRECTOR <b>Brydzinski Funeral Home</b>			25a. DATE REC'D. BY REGISTRAR <b>OCT 23 1987</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.

IMPORTANT: If item 21 is marked or item 18 is marked only injury, or other significant condition, the medical examiner must be notified and advised.

BP

080010 OCT 26 01

NAME	ADDRESS	CITY	STATE	ZIP
James Earl Ray	1000 Franklin Ave. Apt. 209	Memphis	TN	38104
James Earl Ray	1000 Franklin Ave. Apt. 209	Memphis	TN	38104
James Earl Ray	1000 Franklin Ave. Apt. 209	Memphis	TN	38104
James Earl Ray	1000 Franklin Ave. Apt. 209	Memphis	TN	38104
James Earl Ray	1000 Franklin Ave. Apt. 209	Memphis	TN	38104
James Earl Ray	1000 Franklin Ave. Apt. 209	Memphis	TN	38104
James Earl Ray	1000 Franklin Ave. Apt. 209	Memphis	TN	38104
James Earl Ray	1000 Franklin Ave. Apt. 209	Memphis	TN	38104
James Earl Ray	1000 Franklin Ave. Apt. 209	Memphis	TN	38104
James Earl Ray	1000 Franklin Ave. Apt. 209	Memphis	TN	38104

OCT 23 1967  
JAMES EARL RAY  
1000 FRANKLIN AVE. APT. 209  
MEMPHIS, TENN. 38104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (PRINT) FIRST MIDDLE LAST <i>Arthur E. Bucklew Sr.</i>				10 02 87			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 23, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1242 William St. Balto. Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer,		12b. KIND OF BUSINESS OR INDUSTRY Brewery	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY ----- 13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Ernest S. Bucklew				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leona N. Fulty			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.2		17. INFORMANT ADDRESS Charleen F. Brush, Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypercalcemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Bronchogenic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Anemia of Chronic Disease, History of Diverticulosis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>8/25</i> , 19 <i>87</i> , to <i>10/2</i> , 19 <i>87</i> , that (1) (we) lost saw the deceased alive on <i>9/4</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>N. W. Todd MD</i>				DEGREE MD		22c. DATE SIGNED 10/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nevins W. Todd, M.D.				22e. ADDRESS 301 St. Paul Place Baltimore MD 21202			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/5/1987		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A.Co. Md.	
24. FUNERAL DIRECTOR NAME Balto. Md. 21230 ADDRESS McCully Funeral Home, 130 E. Fort Ave.				25a. DATE REC'D. BY REGISTRAR OCT 6 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The objectives of the project are stated in clear, concise terms.

2. The second part of the report is a description of the methodology used in the study. This includes a description of the data sources, the methods of data collection, and the methods of data analysis. The methodology is described in detail so that the reader can understand how the results were obtained.

3. The third part of the report is a description of the results of the study. This includes a description of the data that were collected and a description of the results of the analysis. The results are presented in a clear, concise manner so that the reader can understand what was found.

4. The fourth part of the report is a discussion of the results and their implications. This includes a discussion of the strengths and weaknesses of the study and a discussion of the implications of the results for future research. The discussion is presented in a clear, concise manner so that the reader can understand the significance of the findings.

5. The fifth part of the report is a conclusion. This includes a summary of the findings of the study and a statement of the author's conclusions. The conclusion is presented in a clear, concise manner so that the reader can understand the overall results of the study.

069826 OCT 27 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NAOMI D. BUELLIS			2a. DATE OF DEATH MONTH DAY YEAR 10 22 87		2b. HOUR 3:20 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 3 23	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2423 Washington Blvd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stenographer	12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William F. Lins, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Naomi Livingston		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 216-16-0703	17. INFORMANT ADDRESS Charles Buellis 2423 Washington Blvd. 21230		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Colonic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hepatic failure 2nd metastatic carcinoma</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (Immediate)  1 1/2 yrs  3 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>86</u> , to <u>OCT 22</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-10</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>William Russell</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/22/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Russell		22e. ADDRESS 2521 Washington Blvd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/26/87	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR OCT 26 1987	25b. REGISTRAR'S SIGNATURE <u>Frederick R. Russell</u>

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1052 130 82 830

1052 130 82 830

067982 OCT - 87		FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		28482											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Hazel		M.		Bull				10		1		87				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 72 HRS							
Female		White		9 26 15		72		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Md.		U. S. A.				Baltimore City										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Balto.		3212 Strickland St.		Seamstress													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Balto., Md. 3212 Strickland St. #21229									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Noble		Lipp		Bertha		Kemp											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
		215-12-8021		Mr. Marion R. Tolley		#24459											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
		Probable myocardial infarction		Diabetes mellitus		C.O.P.D.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
		Compressed Thoracic Spine 8-7															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY SYSTEM 18, PART I OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION													
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2/1/87 to 9/29/87, that (I) (we) last saw the deceased alive on 9/29/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED													
Moges Gebremariam		MD		10/2/87													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
MOGES GEBREMARIAM		4660 Wilkens Ave Balto 21229															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		10-5-87		Woodlawn Cem.		Woodlawn Balto. Md.											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
G. Truman Schwab		OCT 07 1987		John Davidson-Randall													
35		60		135		300											
X																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

2001-001-001





**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

28483  
REG. NO.

FOR  
1- STATE  
REGISTRAR

070784 NOV-4-87

DECEASED NAME (1- FOR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Heather Dawn Buniff				Buniff	10-30-87					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Female	White	June, 28/87	4 YRS.	4 MONTHS		10-30-1987				10:10 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA				Baltimore City MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		South Baltimore General Hospital				None				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland		BALTIMORE		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21230 129 W. Randall St. Balto. Md.		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
Vincent F. Buniff				Darlene L. Christopher						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No				None		Mr. Vincent F. Buniff, Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION						
				STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED		
				Deputy Chief				10-31-87		
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS						
Ann M. Dixon, M.D.				111 Penn Street, Baltimore, MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Burial		11/3/1987		Glen Haven Mem. Pk.			Glen Burnie, A.A.Co. Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		
Balto. Md. 21230 McCully Funeral Home 130 E. Fort Ave.				NOV 3 1987						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
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(VR A15 ME (5))

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*For information*

069695 OCT 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Joseph F. Burch, Jr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>October 17, 1987</b>		2b. HOUR <b>5:45 A</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 24 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ala</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5126 Woolverton Ave. 21215</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph F. Burch, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO <b>215-05-7777</b>		17. INFORMANT ADDRESS <b>William Burch 5126 Woolverton Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Disseminated Prostate Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gastrointestinal Bleeding</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Diabetes Mellitus</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>September 28 19 87</b> , to <b>October 17 19 87</b> , that (we) last saw the deceased alive on <b>October 17 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10/17/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Macaulay A. Ojeaga, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>10/22/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C. March F/H West</b>						ADDRESS <b>4300 Wabash Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 23 1987</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

1025130 300030

1025130

068409 OCT 14 87

Items 12a, b, Film G632

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

28485

REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>THOMAS BURCHETT</b>										2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> <b>10-7-87</b>		2b HOUR <b>8:40</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>April 23 1953</b>		6 AGE (IN YEARS) <b>34</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD <b>10-7-87</b>		2d HOUR <b>8:40</b>			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b CITIZEN OF WHAT COUNTRY? <b>USA</b>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital STU</b>						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Operations Mgr. Trucking</b>					
13a STATE <b>Md.</b>				13b COUNTY <b>Balto.</b>				13c CITY OR TOWN <b>Middle River</b>				13d INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET ADDRESS <b>9761 Bird River Road 21220</b>	
14 FATHER'S NAME <b>Bruce Burchett</b>						15 MOTHER'S MAIDEN NAME <b>Hilda Hedrick</b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b SOCIAL SECURITY NO. <b>218-58-8516</b>				17 INFORMANT <b>JeriAnn Burchett</b>				ADDRESS <b>9761 Bird River Road 20</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Cranio-cerebral trauma</b> IMMEDIATE CAUSE (a) <b>9198</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>2:15PM 10-7-87</b>				21b PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>truck stop</b>				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b) <b>wheel head crushed between trailer and frame of trailer</b>							
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>truck stop</b>				21f LOCATION <b>12000blk. Pulaski Hwy. Baltimore Co., Md.</b>							
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>10-8-87</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b DATE <b>10/10/87</b>		23c NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>				23d LOCATION CITY OR TOWN <b>Baltimore</b>		COUNTY <b>Maryland</b>			
24 FUNERAL DIRECTOR <b>Connolly Funeral Home 300 Mace Ave. 21221</b>						25a DATE REC'D BY REGISTRAR <b>OCT 13 1987</b>		25b REGISTRAR'S SIGNATURE <b>via Twister-Randall</b>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (1))



070232 OCT 29 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28480  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ashley C. Burden		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 10 24 1987		2b. HOUR M 8:55A
3. SEX Fe	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 9 1 1987	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 1 23	7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN 1 23
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Infant		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. CITY OR TOWN Balto.		13c. STREET ADDRESS 21223 213 Carrollton Ave.
14. FATHER'S NAME FIRST MIDDLE LAST Kelvin Burden		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kim Davis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) n/a		16b. SOCIAL SECURITY NO. n/a		17. INFORMANT Kim Davis 3653 Park Heights Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant MEDICAL EXAMINER		DATE SIGNED 10/25/87
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St.		Balto. MD.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/28/87	23c. NAME OF CEMETERY OR CREMATORY King Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md.	
24. FUNERAL DIRECTOR NAME James A. Morton & Sons 1701 Laurens St.		25a. DATE REC'D. BY REGISTRAR OCT 27 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL INSIDE THE GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))



01303 01303

20% COTTON FIBRE

MADE IN INDIA



01303 01303



070451 NOV -2-87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 28487

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Herman		R. Burghardt		10 25 87		925 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR IF UNDER 72 HRS	
Male	White	July 14, 1913		74 YRS.			
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Germany	U.S.A.			Baltimore City MD.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Baltimore	Union Memorial Hospital		Cabinet Maker		Furniture		
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Baltimore		Towson		13e STREET ADDRESS / ZIP CODE	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
FRIEDRICH A.H. BURGHARDT		ANNA E. BRETSCHNEIDER		NO			
16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
214-14-5341		Mary J. Burghardt Towson, MD 21204		PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) congestive heart failure			
				DUE TO, OR AS A CONSEQUENCE OF (b) ischemic cardiomyopathy			
				DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerotic cardiovascular disease			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD, osteopenia							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AS WALKER <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that I (this hospital) attended the deceased from 10/22/87 to 10/25/87, that I (we) last saw the deceased alive on 10/25/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.							
22b SIGNATURE		DEGREE		22c DATE SIGNED			
P. G. O'Daniel MD		MD		10/25/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS					
P. G. O'Daniel MD		Union Memorial Hospital					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		OCT. 29, '87		BEL AIR MEMORIAL		HARFORD COUNTY, MARYLAND	
24 FUNERAL DIRECTOR NAME		25 DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD		OCT 30 1987					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies of this certificate and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the body must be handled in accordance with the instructions on the back of this certificate.

BP

050421 101-501

20% COTTON FIBER

WINDY WINTER



069834 OCT 27 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to removal, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Pauline Georgia Burns</b>		2a DATE OF DEATH MONTH <b>10</b> DAY <b>24</b> YEAR <b>87</b> HOUR <b>10</b> MIN. <b>07</b>	
3 SEX <b>Female</b>	4 RACE <b>Caucasian</b> <b>White</b>	5 DATE OF BIRTH MONTH <b>06</b> DAY <b>01</b> YEAR <b>95</b> <b>June 1, 1995</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a STATE <b>MD</b>		13b CITY OR TOWN <b>Baltimore</b>	13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST <b>Jacob</b> MIDDLE <b>Rick</b> LAST <b>ley</b>		15 MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b SOCIAL SECURITY NO. <b>578-18-4326</b>	17 INFORMANT ADDRESS <b>William H. Burns Same as #13</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Poor general condition.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>			
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 14</b> , 19 <b>87</b> , to <b>OCT 24</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>OCT 24</b> , 19 <b>87</b> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <b>F. Wong</b>	DEGREE	22c DATE SIGNED <b>10/24/87</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. F. Wong</b>	22e ADDRESS <b>950 Caton Avenue, Balto, MD 21229</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b DATE <b>10/26/87</b>	23c NAME OF CEMETERY OR CREMATORY <b>Security Process</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Balto, MD</b>
24 FUNERAL DIRECTOR <b>299 Frederick Road 21228</b> NAME ADDRESS <b>Cremation Society of MD, Balto., MD.</b>		25 DATE RECEIVED BY REGISTRAR <b>OCT 26 1987</b>	

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Minnie B Burris</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10/13/87</i>		2b. HOUR <i>12:30 PM</i>					
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3/28/25</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 23 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.				
10. CITY OR TOWN OF DEATH <i>Baltimore MD</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Welder</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Aberdeen</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>PO Box 261 21001</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Audie Lewis</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret Burchett</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>UNK</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>233-32-9044</i>		17. INFORMANT <i>Same</i>			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Brain Death</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Left Coronal Stenosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5-15 min</i> <i>8 days</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION <i>10/5/87</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Internal carotid stenosis</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>P S Ellison, Jr.</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>10/13/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>P S Ellison, Jr.</i>			22e. ADDRESS <i>Univ. of Maryland Hospital Dept of Surgery</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>10/16/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Paul's Lutheran</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Aberdeen Harford Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Tarring funeral Home, PA, Aberdeen, Md.</i>			ADDRESS <i>21001-3399</i>			DATE RECEIVED BY REGISTRAR <i>OCT 16 1987</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DELORES ANN BURRUS			2a. DATE OF DEATH MONTH DAY YEAR 10/2/87		2b. HOUR 6:42 P.M.
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 7 14 52		6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DIETIAN	12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE MD			13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS BURRUS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGIA SMITH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS GEORGIA BURRUS 4605 FREEDOMWAY WEST	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 1 week
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Leukopenia</u>			
19a. DATE OF OPERATION 9/25/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated viscera	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/24/87</u> , 19 <u>87</u> , to <u>10/2</u> , 19 <u>87</u> , that (I) (we) lost the deceased alive on <u>10/2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not, we saw the body after death.)			
22b. SIGNATURE <u>Stevan J. Lawrence</u>	DEGREE (MD)	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/2/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stevan J. Lawrence		22e. ADDRESS Union Memorial Hospital	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10/7/87	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL CO., MD
24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H. INC. 1101 E. NORTH AVENUE		25a. DATE REC'D BY REGISTRAR OCT 06 1987	25b. REGISTRAR'S SIGNATURE T. Wilson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate, page 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
ROBERT				BURTON	5th 10 10 87				6:40 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR	
MALE	BLACK		MONTH DAY YEAR 11 11 12		74 YRS.				IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
NORTH CAROLINA	US of A				City / Baltor.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	Deaton Hospital + Medical Center				Retired				CONSTRUCTION	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE					
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2029 HARLEM AVENUE 21217					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS						
MOSE		BURTON		HENRIETTA FOOTE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT						
NO		246 16 2296A		MRS. EMILY WILSON 2029 HARLEM AVE. 21217						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) METASTATIC BREAST CANCER										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE				22c. DATE SIGNED		
Bhupinder Kaur Singh				MD				10/11/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS						
Bhupinder Kaur Singh										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
BURIAL		10/17/87		WOODLAWN CEMETERY		BALTIMORE (BALTO.) MD.				
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR				
NAME ADDRESS LEWIS T. GWYNN 4517 PARK HEIGHTS AVE. 21215						OCT 13 1987				
						25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall				

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 28492

FOR  
1- STATE  
REGISTRAR

REG. NO.

7. DECEASED NAME (TYPE OR PRINT) FRANCIS Bush			2a. DATE OF DEATH MONTH DAY YEAR 10/27/87			2b. HOUR 11:27 AM				
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 05 17 30		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman		12b. KIND OF BUSINESS OR INDUSTRY State Police		
13a. STATE MD			13b. COUNTY Howard		13c. CITY OR TOWN Elkridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6119 Old Washington Blvd 21227	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Bush			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madeline Nolker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. KOREAN (IF YES, GIVE WAR OR DATES) Korean		17. INFORMANT 214-26-5457 Christopher Bush		5315 Apt A Columbia Rd.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIOPULM ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 10/22, 19 87, to 10/27, 19 87, that (1) (we) last saw the deceased alive on 10/27, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.							
22b. SIGNATURE Thomas Rosenthal		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Rosenthal		22e. ADDRESS Sinai Hospital					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-30-87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Md.	
24. FUNERAL DIRECTOR Harry H. Witzke Funeral Home, Inc.				4112 Columbia Pike Ellicott City, Md. 21043		25a. DATE REC'D. BY REGISTRAR OCT 29 1987	
25b. REGISTRAR'S SIGNATURE Julia Sanders-Rodner							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.



070201 OCT 29 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Katherine L. Busick</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10-26-87</b>		2b. HOUR <b>12:50 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 9 1898</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.	
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pleasant Manor Nursing Home</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS <b>3304 Lerch Drive</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert B. Walter</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara Frederick</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>220-24-1086</b>		17. INFORMANT ADDRESS <b>John S. Busick, Sr., Same as 13c</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>none</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>June 15 1987</b> to <b>Oct 26 1987</b> , that (I) (we) last saw the deceased alive on <b>Oct 26 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.		22b. SIGNATURE <b>Manuel Levin</b> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <b>10/26/87</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MANUEL LEVIN</b> M.D.		22e. ADDRESS <b>6101 PARK HOBBS AVE BALTO MD 21215</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-30-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>		25a. DATE RECEIVED BY REGISTRAR <b>OCT 28 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>Frederick Ruck</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>KATHERINE T. BYRNE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 20 87</b>		2b. HOUR <b>M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH DAY MONTH YEAR <b>10-29-1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>BALTO. MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMPEITAN HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>C+P OPERATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>		13b. COUNTY <b>-</b>	13c. CITY OR TOWN <b>BALTO. CITY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>THOMAS H. BYRNE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MOLLIE MCANALLY</b>		16. ADDRESS <b>- FAMILY RECORDS -</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-05-1595</b>		17. INFORMANT <b>- FAMILY RECORDS -</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION <b>10-12-87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma Pancreas</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <b>10-8-87</b> to <b>10-20-87</b> , that (I) (we) last saw the deceased alive on <b>10-20-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>GOPIAL GURUSWAMY</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10-20-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GOPIAL GURUSWAMY</b>		22e. ADDRESS <b>GSH.</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>10-22-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. CITY MD.</b>		24. FUNERAL DIRECTOR <b>EVAN'S CHAPEL OF MEMORIES</b>			
25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Denson-Randall</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please complete carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST <b>Thomas L. Cain</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 18, 1987</b>		2b. HOUR <b>11:29 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 5, 1940</b>		
6. AGE IN YEARS LAST BIRTHDAY <b>47</b>		7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Francis Scott Key Medical Center</b>		12a. USUAL OCCUPATION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS <b>Beth. Steel</b>		
12b. KIND OF BUSINESS OR INDUSTRY, ETC. <b>Beth. Steel</b>		13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		
13c. CITY OR TOWN <b>Edgemere</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS/ ZIP CODE <b>2544 Lodge Forest Drive 21219</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Geary Cain</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Virginia Crites</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>235-56-3564</b>		17. INFORMANT ADDRESS <b>Marlene C. Cain 2544 Lodge Forest Drive</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS</b>		<b>3 hours</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>PERFORATED COLON</b>		<b>6 hours</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **RETROPERITONEAL ABSCESS**

19a. DATE OF OPERATION <b>10/8/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RETROPERITONEAL ABSCESS</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>600 N. WOLFE, BALTO.</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/6</b> 19 <b>87</b> to <b>10/18</b> 19 <b>87</b> that (I) (we) last saw the deceased alive on <b>10/18</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Abraham</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/19/87</b>	
22d. PHYSICIAN'S NAME				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-22-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Glen</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greenspring Hampshire W. VA</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Fenderson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, pages 2 and 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 would be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a copy of the report filed with this certificate.

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MAINTENANCE

NOTES

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

FOR  
 1- STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AVA M. CALDWELL			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 31, 1987		2b. HOUR 8:25 A M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 13 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secr.		12b. KIND OF BUSINESS OR INDUSTRY Electronics			
13a. STATE Penn.			13b. COUNTY Lancaster		13c. CITY OR TOWN Lancaster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 52 Riverside Avenue 17602		
14. FATHER'S NAME FIRST MIDDLE LAST William Huber			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Conlin								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 169 24 6777			17. INFORMANT ADDRESS Mr. Joseph Long Old Pine Road 17602					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Second</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>MULTI-ORGAN FAILURE - LIVER, KIDNEYS, LUNGS</u>		<u>X 3 DAYS</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS</u>		<u>X 6 DAYS</u>

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

METASTATIC COLON CANCER

19a. DATE OF OPERATION <u>10/27/87</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PERFORATION OF SMALL BOWEL</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 10/11, 19 87, to 10/31, 19 87, that (I) ☒ saw the deceased alive on 10/27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Robert A. Montgomery</u>		DEGREE MO		22c. DATE SIGNED <u>10/31/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT A. MONTGOMERY</u>		22e. ADDRESS 600 N. WOLFE ST. BALTO., MD. 21205			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Nov. 2, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Lancaster Lancaster Penn.</u>	
24. FUNERAL DIRECTOR NAME <u>J. E. Lowell</u> ADDRESS <u>Lemmon Padonia &amp; York Rds.</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 2 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>BERNICE C. CAMPBELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-02-87</b>		2b. HOUR <b>9:10 A.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 1 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Liberty Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS & ZIP CODE <b>2725 Presbury St 21216</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Addison Campbell</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-03-0855A</b>		17. INFORMANT ADDRESS <b>Diane Forney 69 Serpens Ct</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPTICEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>PNEUMONIA</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/4</b> , 19 <b>87</b> , to <b>10/02</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/02</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>BICH T. DUONG</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/2/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BICH T. DUONG</b>		22e. ADDRESS <b>LIBERTY MEDICAL CENTER</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/6/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown Md</b>
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H West</b>		ADDRESS <b>4300 Wabash Avenue</b>		12b. DATE RECD. BY REGISTRAR (REGISTRAR'S SIGNATURE) <b>OCT 05 1987</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Beatrice Camphor			7a. DATE OF DEATH MONTH DAY YEAR 10/22/87		7b. HOUR 9:10 PM
3 SEX Female	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 6 20	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Wade Hamilton Young		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Blackston			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-20-8782		17 INFORMANT ADDRESS Alvin Camphor 2363 Perring Manor Rd	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible Pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 20 min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic renal failure</u>					
19a. DATE OF OPERATION 10/22/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary artery disease/unstable angina		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/21</u> 19 <u>87</u> to <u>10/22</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/23</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED 10/22	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paulile		22e. ADDRESS 225 Greene St Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/27/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md		24 FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Washash Avenue			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE OR ADDRESS OCT 27 1987 <u>[Signature]</u>			

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PROCLAMATION  
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elsie Mae Canning			2a. DATE OF DEATH MONTH DAY YEAR October 1, 1987			2b. HOUR 0350 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 20, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Scott W. Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Muir		13e. STREET ADDRESS 8 Kingbrook Court 21090			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No NA		16b. SOCIAL SECURITY NO. 215.14.8737		17. INFORMANT (Daughter) Eileen M. Canning		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Left CVA.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>LLL. Pneumonia</u>							
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) _____			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> 19 <u>87</u> , to <u>Oct 1st</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Oct. 1st</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>F. Wong</u>		DEGREE <u>MD.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>Oct. 1st.</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Wong</u>		22e. ADDRESS <u>St. Agnes Hospital.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Oct 5, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Glen Burnie A A Co. Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>H. O. Vinsome</u> ADDRESS _____				25a. DATE REC'D. BY REGISTRAR <u>OCT 06 1987</u>			
Singleton Funeral Home Glen Burnie, Maryland				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose this permit, page 4, and this certificate in the container for the deceased with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nathan Canter			2a. DATE OF DEATH MONTH DAY YEAR 10 11 87			2b. HOUR 12:50 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-14-1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret/Self empl		12b. KIND OF BUSINESS OR INDUSTRY Liquor Industry	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Bethesda				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4924 Sentinel Drive, #202	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Cantor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fanny Friedman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-28-9596		17. INFORMANT ADDRESS Bethesda, Md. Rose Canter; Wife; 4924 Sentinel Drive, #202			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) met. ca of the bladder DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct 5, 19 87, to Oct 11, 19 87, that (I) (we) last saw the deceased alive on Oct. 11, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael K. RO MD				DEGREE MD		22c. DATE SIGNED 10/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL K. RO				22e. ADDRESS 900 S CATON AVE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/13/87		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Gdn.; Falls Church; Fairfax; Va.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS NAME ADDRESS 1170 Rockville Pike; Rockville, Md. 20852				25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE OCT 13 1987 Julia Davidson-Randall			

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OCT 13 1961

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. CEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Edward				Caplan	10		13	87	9:30 am.		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
M MALE	W WHITE		7 04 87 04		84 83 YRS.		MONTHS		DAYS		HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.
PENNSYLVANIA	USA				City, Balto.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
City Balto.	South Baltimore General Hosp		SELF-EMPLOYED		MERCHANT						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		APT. 2-A	
MD		BALTO.		City, Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4134 Annapolis Rd.		21227	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		MR. ALLAN J. CAPLAN	
Benjamin		Rachael		NO		212108181		8410 BILSON RD. RANDALLSTOWN, MD		21133	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest.

DUE TO, OR AS A CONSEQUENCE OF

(b) D. I. C.

DUE TO, OR AS A CONSEQUENCE OF

Metastatic Prostate Ca

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/28, 1987, to 10/13, 1987, that (I) (we) last saw the deceased alive on 10/13, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		22b. SIGNATURE Cheng Wai - Fung		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 10/13/87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) CHENG, WAI - FUNG		22f. ADDRESS South Baltimore General Hospital					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		OCT. 14, 1987		BETH TFILOH		BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR OCT 15 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

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upside down  
[Faint handwritten notes and a small sketch of a triangle]

[Faint handwritten notes and a small sketch of a triangle]

[Faint handwritten notes and a small sketch of a triangle]

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68050 OCT-88

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ROSE</b>		3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>1</b> YEAR <b>1946</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS		7a DATE OF DEATH MONTH <b>OCTOBER</b> DAY <b>4</b> YEAR <b>1987</b>		7b HOUR <b>3:30</b> A <b>M</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD							
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waitress</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>					
13a STATE <b>York</b>		13b COUNTY <b>Saratoga</b>		13c CITY OR TOWN <b>Saratoga Springs</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS / ZIP CODE <b>300 Grand Ave 99999</b>							
14 FATHER'S NAME FIRST <b>Robert</b> MIDDLE LAST <b>Hudson</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Viola</b> MIDDLE LAST <b>Benson</b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. <b>063-36-4480</b>		17 INFORMANT <b>Nicholas Capone</b>				ADDRESS <b>New York 12866</b> <b>300 Grand Ave. Saratoga Springs</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Liver Failure</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>24 hours</b> <b>One month</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>(NONE)</b>													
19a DATE OF OPERATION <b>10/11/87</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Liver failure</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>9/17</b> 19 <b>87</b> to <b>10/4</b> 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>10/4</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>M. E. Brady</b>		DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/4/87</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MORRY E. BRADY</b>		22e. ADDRESS <b>Johns Hopkins Hospital</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-10-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Saratoga Springs, Saratoga, N.Y.</b>							
24. FUNERAL DIRECTOR <b>Marzullo Funeral Service</b>				ADDRESS <b>Upperco, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 06 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia T. ...</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

50 22 8/5 0 210



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) <b>PAUL A. CARR</b>		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10-21-87</b>		2b. HOUR <b>2:25</b>
3. SEX <b>M</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 27 46</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS.	7. DATE PRONOUNCED DEAD <b>10-21-87</b>
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1015 N. Calvert Street</b>		12. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>
13. STATE <b>MD</b>		14. COUNTY <b>BALTO.</b>		15. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
16. CITY OR TOWN <b>BALTO.</b>		17. STREET ADDRESS <b>1015 CALVERT STREET APT 2 21202</b>		
18. FATHER'S NAME FIRST MIDDLE LAST <b>CESELS Cecil George Houston CARR</b>		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PAULINE CARR</b>		
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		21. SOCIAL SECURITY NO. <b>218-44 1415-1514</b>		
22. INFORMANT <b>JOY E. FOSTER</b>		23. ADDRESS <b>1102 BARCLAY STREET</b>		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>pneumocystis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>AIDS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>HIV test positive</b>				
25. DATE OF OPERATION <b>10-22-87</b>		26. CONDITION FOR WHICH OPERATION WAS PERFORMED?		27. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
28. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		33. LOCATION CITY OR TOWN COUNTY STATE
34. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
35. ACTUAL SIGNATURE <b>Margarita A. Korell</b>		36. TITLE (SPECIFY) <b>Assistant</b>		37. DATE SIGNED <b>10-22-87</b>
38. EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		39. ADDRESS <b>111 Penn Street</b>		
40. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		41. DATE <b>10/27/87</b>		42. NAME OF CEMETERY OR CREMATORY <b>GARRISON FOREST VA CEMETERY</b>
43. FUNERAL DIRECTOR NAME <b>WM. C. MARCH F/H, INC.</b>		44. ADDRESS <b>1101 E. NORTH AVENUE</b>		45. DATE REC'D BY REGISTRAR <b>OCT 26 1987</b>
46. REGISTRAR'S SIGNATURE <b>[Signature]</b>		47. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

20% COTTON FIBER

MADE IN U.S.A.



70426 NOV -2 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28504

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			7a DATE KNOWN OF DEATH			MONTH DAY YEAR			7b HOUR			
WILLIAM L. CARR, Jr.						10-29-87						M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c DATE PRONOUNCED DEAD		7d HOUR	
M		B		6 7 44		43 YRS.						10-29-87		1:54a	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH			
Md.				USA								Baltimore City			
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY			
Baltimore				3811 Reisterstown Road				Laborer				Blue Chip			
13a STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS?			
Md.								Balto.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME				16a WAS DECEASED EVER IN U.S. ARMED FORCES?				16b SOCIAL SECURITY NO.			
William Carr, Sr.				Georgia Haskins				no				214 10 8418			
17 INFORMANT				ADDRESS				17a DATE OF OPERATION				17b CONDITION FOR WHICH OPERATION WAS PERFORMED?			
Olivia V. Carr				4121 Park Hghts Ave.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Fatty liver</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) <u>storing the underlying cause last.</u>															
(b) <u>alcoholism</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f LOCATION							
								CITY OR TOWN COUNTY STATE							
22a I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion															
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Dennis F. Smyth</u> M.D. Assistant MEDICAL EXAMINER DATE SIGNED 10-29-87															
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn Street															
23a BURIAL, CREMATION, REMOVAL				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION			
Burial				11/3/87				Arbutus				Balto., Md. STATE			
24 FUNERAL DIRECTOR NAME								25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Jas. A. Morton & Sons 1701 Laurens St.								OCT 30 1987		Julia Davidson-Randall					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 54 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))

RECEIVED

NOV 11 1964



NOV 11 1964

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

2 8 5 0 3

1- FOR  
STATE  
REGISTRAR

068428 OCT 14 1987

1. DECEASED NAME (PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Albert		S.				Carter, Jr		10/ 8/ 1987								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	black	8 23 1948		39 YRS.						10/ 8/ 19 87						P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
N.Y		U S A				Baltimore City, MD.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore				Liberty Medical Center				Disabled									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2908 Garrison Blvd 21216									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)									
Albert				Carter, Sr				Emma				Carter					
16a. No				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
				069-38-2854				Beulah Carter				2908 Garrison Blvd apt5A					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure Disorder DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) Chronic Renal Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED					
Dennis F. Smyth, M.D.				Assistant								10/9/87					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE					
Dennis F. Smyth, M.D.				111 Penn St., Balto., Md. 21201				Burial				10/12/87					
								23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
								Camden Cemetery				Camden S.C.					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Wm. C. March F/H West				4300 Wabash Avenue				OCT 13 1987				Julia Anderson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

50 41 130 8 2 10 30



50 41 130 8 2 10 30

BP  
DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, attend a medical examiner who has the right of autopsy.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME FIRST MIDDLE LAST DAVID EDGAR Carter					2a. DATE OF DEATH MONTH DAY YEAR 10 18 87				
3. SEX MALE					4. RACE White				
5. DATE OF BIRTH MONTH DAY YEAR 05 03 30					6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HOWARD G. Md.					7b. CITIZEN OF WHAT COUNTRY? U.S.A.				
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH Baltimore					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. AGNES HOSPITAL				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAREHOUSE					12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.					13b. COUNTY HOWARD				
13c. CITY OR TOWN ELLICOTT City					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13e. STREET ADDRESS 3133 A NORMANDY Woods Dr.									
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD BOOTEN CARTER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE AGNES STAUFFER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) KOREAN 213-26-7393				
17. INFORMANT Helen E. Carter -					ADDRESS 3133 A NORMANDY Woods Dr. ELLICOTT City, Md. 21043				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Liver Cirrhosis, Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 20</u> , 19 <u>87</u> , to <u>OCT. 18</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>OCT. 18</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Khaled RiKabi					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 10/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Khaled RiKabi					22e. ADDRESS 900 CATON AVE, S.A.H.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10-21-87		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd			23d. LOCATION CITY OR TOWN COUNTY STATE ELLICOTT City Howard Md.	
24. FUNERAL DIRECTOR NAME SLACKS FUNERAL HOME					ADDRESS 3871 Old Cal. Pk. ELLICOTT City, Md.		25a. DATE REC'D. BY REGISTRAR OCT 22 1987		
					25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall				

069604

OCT 23 87

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1- DECEASED NAME (TYPE OR PRINT) <b>Elwanda TYRE Carter</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 21 87</b>			2b. HOUR <b>12:30 PM</b>					
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 5, 1943</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>44</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MIEMSS</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Georgia</b>			13b. COUNTY <b>Wayne</b>		13c. CITY <b>Screven</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>P.O. Box 374 31560</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Feldon UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Myrtle Robertson</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>260-68-7840</b>	
17. INFORMANT <b>Rinehart &amp; Sons Funeral Home</b>			18. ADDRESS <b>860 Hwy 301 South, Jesup, GA 31545</b>								
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Air embolism to brain</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriogram</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>postop From AUM resection</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>24 hrs</b> <b>6 days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION <b>10/15/87</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Arteriovenous malformation</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>10/20</b> , 19 <b>87</b> , to <b>10/24</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/20</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Sm Congilosi</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>10/24/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sm Congilosi</b>			22e. ADDRESS <b>MIEMSS Baltimore, MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Oct. 24, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Screven City</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Screven Wayne, GA</b>				
24. FUNERAL HOME OR OTHER INSTITUTION NAME ADDRESS <b>ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, Md. 21214</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 22 1987</b>		25b. REGISTRAR'S SIGNATURE				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

20. DATE KNOWN OF DEATH ☐ MONTH ☒ DAY ☐ YEAR 10 14 1987 2b HOUR 6:51 A.M.

1. DECEASED NAME (TYPE OR PRINT) JAMES E. CARTER		20. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR 10 14 1987 2b HOUR 6:51 A.M.	
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 1 4 1930	6. AGE (IN YEARS) (LAST BIRTHDAY) 57 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1701 Eutaw Place	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled
13a. STATE Md		13b. COUNTY	13c. CITY OR TOWN Baltimore
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Hamilton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. Jordan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 213-28-0517	17. INFORMANT Isabelle Hamilton
		ADDRESS 3312 Spaulding Avenue	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Chronic renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☐. and in my opinion death resulted from Natural causes ☒. Assault ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐.

ACTUAL SIGNATURE Mario F. Galle, Jr. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-14-87  
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Galle, Jr., M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/19/87	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue		25. DATE REC'D BY REGISTRAR <u>OCT 20 1987</u> 26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10.3. RETAIN PAGE 5 PER YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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(VR A15 ME (5))



068441 OCT 14 1987

FOR  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28509

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) RONTA D. CARTER			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 10 10 1987			2b. HOUR M 6P
3. SEX Male	4. RACE 2	5. DATE OF BIRTH MONTH DAY YEAR 5 25 86	6. AGE (IN YEARS) LAST BIRTHDAY 1 YRS. 4 MONTHS 15 DAYS	IF UNDER 1 YR. MONTHS DAYS 4 15	IF UNDER 24 HRS. HOURS MIN. 15	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 10 1987
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		10. CITY OR TOWN OF DEATH Baltimore				
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2542 Pennsylvania Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Infant		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2543 Penna Ave. 2/217		
14. FATHER'S NAME FIRST MIDDLE LAST Elyvn Carter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lynn L. Royester			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Mr. Elyvn Carter 2543 Penna Ave. 2/217		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke inhalation &amp; thermal injuries</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <u>XX</u> MONTH DAY YEAR 5:50 P.M. 10-10-1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) House fire.		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2542 Pennsylvania Ave., Balto. City MD		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>Mario F. Colle, Jr.</i>		TITLE (SPECIFY) Assistant MEDICAL EXAMINER			DATE SIGNED 10-11-87	
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Colle, Jr., M.D.		ADDRESS 111 Penn St., Balto., MD 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-15-87	23c. NAME OF CEMETERY OR CREMATORY Arbutus		23d. LOCATION CITY OR TOWN Balto	COUNTY Md.	STATE
24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons			ADDRESS 1701 Laurens		25a. DATE REC'D. BY REGISTRAR OCT 13 1987	
			25b. REGISTRAR'S SIGNATURE Julia Twicken-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please call on the funeral directors, pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR			P					
JOSEPH			CASKEY			JR			OCTOBER			12, 1987			4:00			M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE			(IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR			IF UNDER 24 HRS.					
Male			White			December 16, 1986			YRS			9			26			HOURS			MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY			MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			BALTIMORE			THE JOHNS HOPKINS HOSPITAL			Dependant					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			1624 Grayhaven Ct. 21222								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS								
Joseph			A. Caskey, Sr.			Joan McDonough			No			-----			Joseph A. Caskey, Sr. 1624 Grayhaven Ct.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>overwhelming infection.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>multiple congenital anomalies.</u>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>0 min</u> <u>24 hours.</u> <u>10 months.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
												YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from <u>09/17</u> 19 <u>87</u> to <u>10/12</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>10/13</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>Bradley B. Keller MD</u>																DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>10/12/87.</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Bradley B. Keller MD</u>																22e. ADDRESS <u>Johns Hopkins Hospital - Pediatrics</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial				10-15-87				Sacred Heart of Jesus				Baltimore Maryland											
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
Duda-Ruck Funeral Home of Dundalk				OCT 14 1987				<u>Julia Davidson-Kardata</u>															
7922 Wise Ave. Dundalk, MD 21222																							

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>GEORGE HARDY CASSELS-SMITH</b>			2a DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 1, 1987</b>			2b HOUR <b>10:15</b> P			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Aug. 16, 1932</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pres. Tech.</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>	
13a STATE <b>Md.</b>		13b CITY OR TOWN <b>Balto.</b>		13c CITY OR TOWN <b>Upperco</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>4440 Mt. Zion Rd. 21155</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Royce Cassels-Smith</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn Gieske</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>213-30-3667</b>		17. INFORMANT ADDRESS <b>4440 Mt. Zion Rd., Jeremy B. Cassels-Smith Upperco, Md. 21155</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral herniation</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>29h</b> <b>48h</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Ischemic heart disease</b>									
19a DATE OF OPERATION <b>9/28/87</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary Artery disease</b>				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>09-29-</b> 19 <b>87</b> to <b>10-01-</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10-01-</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Johnny E. Brown MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>10/1/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Johnny Edward Brown</b>				22e ADDRESS <b>Johns Hopkins Hospital</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Oct. 3, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24 FUNERAL DIRECTOR <b>H. E. Ehlhardt</b>				ADDRESS <b>Owings Mills, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 05 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, and after the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the funeral director. Pages 1 and 2 should be filed with the records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

NAME

PLACE

REMARKS

DATE

TIME

REMARKS

DATE

TIME

REMARKS

REMARKS

068946 OCT 20 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>WALTER CATES</b>			2b. DATE OF DEATH MONTH DAY YEAR <b>10/14/87</b>		2c. HOUR <b>9:50 PM</b>	
3 SEX <b>M</b>	4 RACE <b>B</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>05 23 07</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ROXSBOUGH, N.C.</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.		
10 CITY OR TOWN OF DEATH <b>BALTO.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD</b>		13b COUNTY <b>BALTIMORE</b>	13c CITY OR TOWN <b>BALTIMORE</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>3927 BAVIERA AVE 21215</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOHN CATES</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSA COLLINS</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>PAULETTE GRIFFIN 3639 WOODSDALE RD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MULTISYSTEM FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <b>7/13/87</b> , 19 <b>87</b> , to <b>10/14</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/14</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <b>T. Rosenthal</b>				DEGREE <b>MD</b>		22c DATE SIGNED <b>10/14/87</b>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS ROSENTHAL</b>				22e ADDRESS <b>SINAL HOSPITAL</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>10/19/87</b>		23c NAME OF CEMETERY OR CREMATORY <b>WESTERN STAR CEM.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTO., MD</b>
24 FUNERAL DIRECTOR NAME ADDRESS <b>LEROY O. DYETT &amp; SON 4600 LIBERTY HGTS.</b>				25a DATE REC'D. BY REGISTRAR <b>OCT 16 1987</b>		25b REGISTRAR'S SIGNATURE <b>Richard R. ...</b>

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to give

1901 JUL 3 40030

Handwritten notes and tables are visible but extremely faded. The text is mostly illegible due to the quality of the scan. There are some faint markings that appear to be numbers and possibly names, but they cannot be transcribed accurately.

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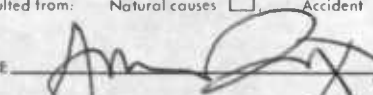
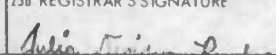
Item 18, 21b, c, d, f G632 10-12-87 dw

STATE OF MARYLAND

2 8 3 1 3

FOR  
STATE  
REGISTRAR  
per med examDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Wilbert L. Causion</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10/ 11/ 19 87</b>			2b. HOUR A M <b>10:20 A M</b>					
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4/29/49</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>38 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3941 Greenmount Ave.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>---0---</b>			12c. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE 12b. COUNTY 12c. CITY OR TOWN <b>Md None Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>2503 Halcyon Ave. 21214</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wilbur Causion</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jean(Causion) Amos</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>---0---</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-54-5344</b>			17. INFORMANT ADDRESS <b>Jean Causion, 4454 Saint George Av</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Alcohol and narcotic intoxication</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>10-10 19 87</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject used drugs</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Maryland</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. <b>Deputy Chief</b> MEDICAL EXAMINER						DATE SIGNED <b>10/12/87</b>		
EXAMINER'S NAME TYPE OR PRINT <b>Ann M. Dixon, M.D.</b>			ADDRESS <b>111 Penn St., Balto., Md. 21201</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/16/87</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Md. Nat. Mem. Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Law Funeral Home 4611 Park Heights Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 20 1987</b>			25b. REGISTRAR'S SIGNATURE 		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. ONE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS--901 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Hannah Chambers</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 25, 1987</b>		2b. HOUR <b>1:45 am</b>						
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-31-1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (DURE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>501 Dolphin St. 21217</b>			
14. FATHER'S NAME (PRINT) FIRST MIDDLE LAST <b>William Chambers</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Gardner</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-22-9688</b>		17. INFORMANT <b>Alice Turner</b>				ADDRESS <b>501 Dolphin Street</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
9a. DATE OF OPERATION			19a. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (x) (this hospital) attended the deceased from <b>October 19, 1987</b> , to <b>October 25, 1987</b> . The (we) last saw the deceased alive on <b>October 25, 1987</b> , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Henri Nammour, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/26/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henri Nammour, M.D.</b>						22e. ADDRESS <b>c/o Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10-29-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY</b>		INCORPORATION OR TOWN <b>Balto.</b>		COUNTY <b>Md.</b> STATE		
24. FUNERAL DIRECTOR NAME <b>James A. Morton</b>						ADDRESS <b>1701 Laurens St.</b>		25a. DATE REC'D. BY REGISTRAR <b>10/27/87</b>		25b. REGISTRAR'S SIGNATURE <b>James A. Morton</b>	





068975 OCT 20 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 28515

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ARTHUR JAMES CHANEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 17 87</b>		2b. HOUR <b>4<sup>30</sup> AM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 8 26</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GEN. HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT MARINE GUARD</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TERMINAL</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Chaney</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lottie Mae Gasaway</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW II 219-18-7355</b>		17. INFORMANT ADDRESS <b>Helen Sleighter 604 Edward Rd. 21401</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**METASTATIC CARCINOMA of COLON**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>10/06/1987</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA PERITONEII</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from <b>10/05/87</b> to <b>10/17/87</b> , that (I) (we) last saw the deceased alive on <b>10/17/87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Kwang N. Kim</b>		DEGREE <b>MD</b>	22c. DATE SIGNED <b>10-17-87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KWANG N. KIM</b>		22e. ADDRESS <b>3001 S. HANOVER ST. 21225</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10/20/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville Vet. Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville A.A. Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>OCT 19 1987 Julia Pearson-Randall</b>	

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COPIES LIBEL

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Item 18a, 22a 10-8-87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28510

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Toney CHAVIS Jr.

2a DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 9 1 19 87

2b HOUR 1:24 A.M.

3 SEX M 4 RACE Amer. Ind. 5 DATE OF BIRTH MONTH DAY YEAR 9-3-1956 6 AGE (IN YEARS LAST BIRTHDAY) 30 YRS.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina 7b CITIZEN OF WHAT COUNTRY? USA 8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10 CITY OR TOWN OF DEATH Baltimore 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Roofer 12b KIND OF BUSINESS OR INDUSTRY Roofing

13a STATE Md. 13b COUNTY 13c CITY OR TOWN Baltimore 13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS 21231 20 S. Patterson Pk. Ave.

14 FATHER'S NAME FIRST MIDDLE LAST Doug Locklear 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Chavis

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b SOCIAL SECURITY NO. 215-74-5268 17 INFORMANT ADDRESS Angela Kincaid 2143 Cambridge St.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Probable Cardiac Arrhythmia  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
(b)  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES ☒ NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE [Signature] M.D. Deputy Chief MEDICAL EXAMINER DATE SIGNED 9-1-87

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b DATE 9-3-87 23c NAME OF CEMETERY OR CREMATORY Oaklawn 23d LOCATION CITY OR TOWN COUNTY STATE Balto. MD.

24 FUNERAL DIRECTOR NAME ADDRESS John M. Weber & Sons, INC. 401 S. Chester St. 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE SEP 04 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN EACH OF ITEMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 BP 752 DHMH - 17 (VR A15 ME (5))

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Irene T. Cherry</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 19, 1987</b>		2b. HOUR <b>10<sup>30</sup> PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 24 1918</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6601 Walther Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>St. of Md.</b>		13a. STREET ADDRESS / ZIP CODE <b>6601 Walther Avenue 21206</b>				
13b. COUNTY <b>Maryland</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Stanley Cherry</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Marcinkowski</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-12-3758</b>		17. INFORMANT ADDRESS <b>Jaqueline L. Kelly 8619 Trumps Mill Rd.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic breast cancer</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____						
DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>4/23/85</b> to <b>10/19/87</b> , that (we) lost saw the deceased alive on <b>10/12/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>George Lowe</b>		DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/20/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George Lowe, M.D.</b>		22e. ADDRESS <b>3703 Belair Road Baltimore, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-23-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dundalk Baltimore MD.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>				
25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column 18. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DATE

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C.A.A.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN D. CHESTER			2a DATE OF DEATH MONTH DAY YEAR 10 5 87		2b HOUR M
3 SEX male	4 RACE black	5 DATE OF BIRTH MONTH DAY YEAR 11 5 1922	6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	
7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.		
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2507 W. MOSHER STREET		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
13a STATE Md		13b COUNTY	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Norman Chester, Sr		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Hall			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		16b SOCIAL SECURITY NO. 216-16-9155		17 INFORMANT ADDRESS Beverly Robinson 2511 W. Mosher Street	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE LUNG WITH BONE METASTASIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SAME AS ABOVE</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>SEP 7 7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>David J. Settleman</u> THE PHYSICIAN'S NAME (TYPE OR PRINT)		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/7/87	
22d ADDRESS 160 N HANAWAY BALTO MD 21231					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/10/87	23c NAME OF CEMETERY OR CREMATORY Garrison Forest Vet		23d LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md	
24 FUNERAL DIRECTOR NAME WM. C. MARCH F/H 4300		ADDRESS WABASH AVENUE		25a DATE REC'D. BY REGISTRAR OCT 8 1987	
				25b REGISTRAR'S SIGNATURE <u>Julia D. Robinson</u>	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

068216 OCT-987

10/17







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Childs Baby Girl			2a. DATE OF DEATH MONTH DAY YEAR 10-31-87			2b. HOUR 4 M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 31 87			6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 1 30		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital NICH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA			12b. KIND OF BUSINESS OR INDUSTRY NA	
13a. STATE NA			13b. COUNTY NA		13c. CITY OR TOWN NA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE I. CHILDS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zelda Childs					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NA		16b. SOCIAL SECURITY NO. NA		17. INFORMANT ADDRESS Janice Wilson RN WHP 225 W. Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extreme Prematurity (21wks) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 112 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) None									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —					
22. I certify that (I) (this hospital) attended the deceased from 10-31 (2087) 19 87, to 10-31-87 @ HP, that (I) (we) last saw the deceased alive on 10-31 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Janice Wilson RN WHP				DEGREE —		22c. DATE SIGNED 10-31-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. Ronald Nutterlet				22e. ADDRESS Mercy Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 11-5-87		23c. NAME OF CEMETERY OR CREMATORY —		23d. LOCATION CITY OR TOWN COUNTY STATE —			
24. FUNERAL DIRECTOR NAME State Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR NOV 09 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

 Item #16b., G-634, 12/18/87, by F.H., per STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

1. FOR copy of S.S.Card,/ Gbj. STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR a	
DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST MIDDLE LAST		Female		White	
VIRGINIA BULL		CHILDS		October 23, 1987	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR a	
June 5, 1888		99 YRS.		8:40 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
MD		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		Meridian Homewood		Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE		13b. CITY OR TOWN	
Own Home		3404 Old York Rd., 21218		Balto.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD		Balto.		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
(Unknown) Bull		(Unknown)		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD	
212-74-7598		Mrs. Jack W. Neely, Balto., MD		DUE TO, OR AS A CONSEQUENCE OF (b) DEMENTIA	
213 12 0411				DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
				P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
				21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 10/25/87 to 10/25/87, that (we) lost		22b. SIGNATURE		22c. DATE SIGNED	
saw the deceased alive on 10/25/87, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		DEGREE		10/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE RECEIVED BY REGISTRAR	
Dr. Timothy Bessent, MD		St. Joseph's Hospital, Balto., MD		OCT 26 1987	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10/26/87		Grace Church Cem. Balto., MD	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25. REGISTRAR'S SIGNATURE	
H.W. Jenkins & Sons Co.				Julia Dindor-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) JAN KONG CHIN			2a. DATE OF DEATH MONTH DAY YEAR 10 14 87		2b. HOUR 5:25 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 10 92		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Que Chin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dia Ng						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-34-2943		17. INFORMANT ADDRESS Johnnie Chan 1234 E. Belvedere Ave. 21239				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hypertension</u> (b) <u>Coronemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastrointestinal bleeding, Cag Sigmoid Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE ANY OTHERS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> 19 <u>87</u> to <u>10/14</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Ambacher Woreta MD</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>10/14/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMBACHER WORETA			22e. ADDRESS NORTH CHARLES HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/21/87		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto. Co., Md.		
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld			ADDRESS Home, Inc. Balto., Md. 21212			25. DATE REC'D. BY REGISTRAR OCT 23 1987			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Reba Chisholm</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/23/87</b>			2b. HOUR <b>225 AM</b>		
3. SEX <b>F</b>	4. RACE <b>XB</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 8 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
13a. STATE <b>MD</b>			13b. COUNTY <b>BALTO.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>1418 N. BOND STREET 21213</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH HARRIAGE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH WHITE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. <b>800-03-2608</b>		17. INFORMANT ADDRESS <b>LAWSON CHISHOLM 1418 N. BOND STREET</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>bowel obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic colorectal carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <b>Renal failure</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. certify that (I) (this hospital) attended the deceased from <b>10/12</b> , 19 <b>87</b> , to <b>10/23</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/23</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>[Signature]</b>			DEGREE <b>MD</b>			22c. DATE SIGNED <b>10/23/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J Washington</b>			22e. ADDRESS <b>Mercy Hospital 3015 Paul Rd Baltimore</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10/28/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT CALVARY CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ANNE ARUNDEL CO., MD</b>	
24. FUNERAL DIRECTOR NAME <b>WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 27 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

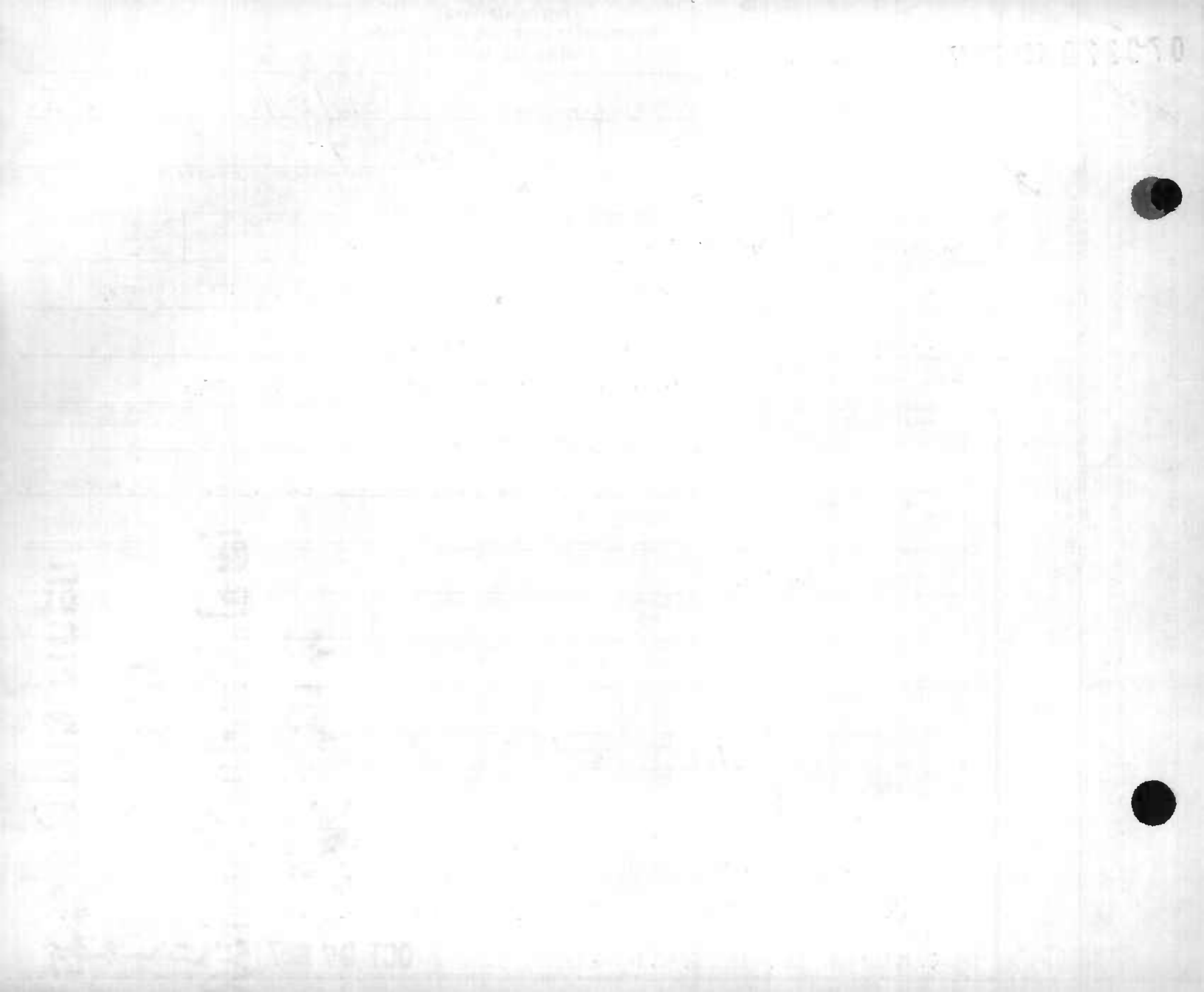
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charles P. Clark</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 22 1987</b>		2b. HOUR <b>5:30 A.M.</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 23 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, City MD.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>WOOD PATTERN MAKER</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>MARTIN CO.</b>						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13d. STREET ADDRESS <b>3441 CLIFTMONT AVE. 21213</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES C. CLARK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FLORENCE PATTERSON</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-14-0871</b>		17. INFORMANT ADDRESS <b>DAISY CLARK (WIFE) SAME ADDRESS</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Acute Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic adenocarcinoma of the colon</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Sepsis</b>						
19a. DATE OF OPERATION <b>Oct. 2, &amp; 9, 1987 Sept. 23, 1987</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Peritoneal abscess Perforated carcinoma of the cecum</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (if this hospital) attended the deceased from <b>September 21 19 87</b> , to <b>October 22 19 87</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>October 22 19 87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> I did not view the body after death.						
21b. SIGNATURE 		DEGREE		22c. DATE SIGNED <b>10/22/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen L. Huhn, M.D.</b>		22e. ADDRESS <b>C/O Maryland General Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/26/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTERN CEMETERY</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>						
24. FUNERAL DIRECTOR <b>SCHIMUNEK FUNERAL HOME</b>		25a. DATE REC'D BY REGISTRAR <b>OCT 23 1987</b>		25b. REGISTRAR'S SIGNATURE 		
25c. ADDRESS <b>3331 Brehms Lane Balto. Md. 21213</b>						

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate to registrars. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Harvey W. Clark					2a. DATE OF DEATH MONTH DAY YEAR 10 8 87				2b. HOUR 1:15 A.M.
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 14, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Deaton Med. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Fire Marshall		12b. KIND OF BUSINESS OR INDUSTRY Calvert	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 822 E. Fort Ave. Balto. Md. 21230
14. FATHER'S NAME FIRST MIDDLE LAST Harvey M. Clark					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie B. Bridner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 212-05-2277		17. INFORMANT ADDRESS Mrs. Catherine O. Clark, Same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SP GT bleed a surgery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>paraplegia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>paraplegia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 3 months
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/15/87</u> to <u>10/8/87</u> , that (we) last saw the deceased alive on <u>10/8/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.									
22b. SIGNATURE J.A. Gladue, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/12/87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemt.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Home, 130 E. Fort Ave.					25a. DATE REC'D. BY REGISTRAR OCT 09 1987		25b. REGISTRAR'S SIGNATURE John Davidson		

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E LAST CLARK			2a DATE OF DEATH MONTH DAY YEAR 10 12 87			2b HOUR 4:00 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 26 1909		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7c CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY -	
13a STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET ADDRESS / ZIP CODE 5501 Key Avenue, 21215			14 FATHER'S NAME FIRST MIDDLE LAST Klaus Shoop			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Reiter			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 218-12-6011		17 INFORMANT ADDRESS Rose Ann Honemann, 2318 Harcroft Rd., 21093				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) renal failure DUE TO, OR AS A CONSEQUENCE OF (b) sepsis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a DATE OF OPERATION N/A			19b CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f LOCATION STREET CITY OR TOWN COUNTY STATE N/A				
22a. I certify that (I) (this hospital) attended the deceased from Oct 6, 1987, to Oct 12, 1987, that (I) (we) last saw the deceased alive on Oct 12, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Mary J. Honemann MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-12-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Mary J. Honemann MD			22e ADDRESS Sinai Hospital, Baltimore, MD 21215						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 10/13/87		23c NAME OF CEMETERY OR CREMATORY Westview Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.		
24a BY WHOM Bryan W. Clary			24b ADDRESS 10 W. Padonia Rd., 21093			25a DATE REC'D. BY REGISTRAR OCT 13 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

000230 OCT 1971

OCT 13 1971

069033 OCT 20 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RICHARD W. CLARK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-14-87</b>			2b. HOUR <b>6:30 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-31-29</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General</b>				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>SEVERN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1608 Severn Rd 21144</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Clark</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary York</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT <b>Vere Clark</b>			ADDRESS <b>Sever</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melastotic Ca of Mouth</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/14/87</b> , 19____, to <b>10/14/87</b> , 19____, that (I) (we) last saw the deceased alive on <b>10/14/87</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>J. Calabrese</b>				DEGREE		22c. DATE SIGNED <b>10/14/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JURGE E. WILKINSON</b>				22e. ADDRESS <b>South Baltimore General H</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>10-17-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balt. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Hardesty Funeral Home</b>				ADDRESS <b>Annapolis, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 16 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



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OCT 10 1981



070404 NOV 1987

FOR  
REGISTRAR#18, 21a, 21b, 21c, 21d, 21e,  
12/18/87 Gw 634STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		KNOWN ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
David		J.		Clary				10		25		19		87				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
male	black	2 16 1955		32 YRS.						10		25		1987				5:28 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Md		U S A				Baltimore City												MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		Sinai Hospital																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5204 Elmer Avenue 21215											
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST									
Willie		A.		Clary		Pauline				PRYOR									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No				358-48-5051		Marion Walker		10 Bitterroot Ct Apt F											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head injury with complications</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 6/29 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) unknown															
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown		21f. LOCATION STREET CITY OR TOWN COUNTY STATE unknown															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .																			
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		10/26/87											
EXAMINER'S NAME (TYPE OR PRINT)		Mario F. Golle, Jr., M.D.		ADDRESS		111 Penn St.		Balto. MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		10/30/87		Mt Calvary Cemetery		Anne Arundel Co. Frederick Md													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Wm. C. March F/H West		4300 Wabash Avenue		OCT 30 1987															

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

010104 H21-501

PLEASE PRINT NAME AND ADDRESS

NAME  
ADDRESS  
CITY  
STATE  
ZIP



070396 NOV-28

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILMA PARKER CLAYTON			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 26, 1987		2b. HOUR 8:54A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 26, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant	12b. KIND OF BUSINESS OR INDUSTRY Retail	
13a. STATE Virginia			13b. COUNTY Accomack	13c. CITY OR TOWN Parksley	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Wilmer Parker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Lee Bull		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 227-24-0724		17. INFORMANT ADDRESS Jesse D. Clayton P. O. Box 24 Parksley, Va. 23421	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal failure, sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>mesenteric / renal infarction</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 min</i> <i>4 weeks</i> <i>4 weeks</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>renal failure, embolic event</i>					
19a. DATE OF OPERATION <i>9/25 &amp; 9/28/87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>mesenteric infarction</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9/20</i> , 19 <i>87</i> , to <i>10/26</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>10/26</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Mary</i>		DEGREE		22c. DATE SIGNED <i>10/20</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARY EYHUN, JESSIE RENEE</i>		22e. ADDRESS <i>Johns Hopkins Hosp</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/28/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parksley Cemetery</i>	
23d. FUNERAL DIRECTOR <i>John J. Williams</i>		23e. ADDRESS <i>P. O. Box 527 Parksley, Va.</i>		23f. LOCATION CITY OR TOWN COUNTY STATE <i>Parksley Accomack Va.</i>	
24. DATE REC'D. BY REGISTRAR <i>OCT 30 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Williams</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070300 NOV-58

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FOR  
STATE  
REGISTRAR

Item #6 Film G 632

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

10/15/87 per Leroy O. Dvett fs

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Hattie		Clement		-10		3 87		6:45 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		Black		MONTH DAY YEAR		96 95		MONTHS DAYS	
				04 22 92				HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina		USA				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore City		Deaton Hospital & Medical Center							
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21223 1914 West Saratoga Street	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Lewis Hubert				Anna Taylor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		N/A		213 30 7394A		GERALDINE PENDLETON 1833 PACIFIC			

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Probable Breast Carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (c) _____	

MEDICAL CERTIFICATION	PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <i>Decubiti, Degenerative arthritis, anaemia, CHF</i>			
	19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
	21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/14/86</i> , 19____, to <i>10/3/87</i> , 19____, that (I) (we) lost saw the deceased alive on <i>9/2/87</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Spaehlin</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10/6/87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jyoti Parikh, MD</i>		22e. ADDRESS <i>7445-A Furnace Branch Rd, GB-210</i>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL		10/9/87	ARBUTUS MEM.	BALTO	MD	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		
LERÖY O. DYETT 4600 LIBERTY HEIGHTS				OCT 15 1987		
				25b. REGISTRAR'S SIGNATURE <i>Julia D. [Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all blank pages except page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

**IMPORTANT:** If item 2) is marked or new 18 shows any injury, or other traumatic event, the medical examiner must be notified as outlined in the instructions.

MEDICAL CERTIFICATION

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001 100 001 001

001 100 001 001



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Garfield JACKSON Clifton</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 10 87</b>					2b. HOUR <b>3:58 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 9 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Leumdale CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PIPEFITTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BALTO CITY</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>SEVERN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>902 LOCUST WOOD ROAD 21144</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EMORY CLIFTON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LETHA HAMRICK</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>W.W. II 234-12-1062</b>		17. INFORMANT ADDRESS <b>CHERYL WILLIAMS SISTER IN LAW CROWNSVILLE MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Cerebrovascular Accident</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from <b>9/28</b> , 19 <b>87</b> , to <b>10/10</b> , 19 <b>87</b> , that (b) (we) last saw the deceased alive on <b>10/10</b> , 19 <b>87</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Estrelita O. Ku</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10/10/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELITA O. KU</b>				22e. ADDRESS <b>LEVINDAVE HEBREW GERIATRIC CENTER HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>OCT. 13, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN MEM PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>GLEN BURNIE A.A. MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>SINGLETON FUNERAL HOME, GLEN BURNIE, MD.</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 13 1987</b>		25b. REGISTRAR'S SIGNATURE <b>William P. ...</b>			

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

28531  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Florence E. Cole</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 6 87</i>			2b. HOUR <i>853 a.m.</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 13 23</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bon Secours</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD</i>				13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph B. Baker</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Martha A. Myles</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>215-46-1933</i>		17. INFORMANT <i>William Cole</i> ADDRESS <i>1430 N. Fulton Ave Baltimore, Md. 21217</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recurrent Cerebrovascular Accidents</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>cerebral infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>unknown</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>end stage renal disease on dialysis, hypertension, seizures &amp; fever (unknown origin)</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <i>October 5</i> 19 <i>87</i> , to <i>October 6</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>October 6</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LINDA F. SLOAN</i>				23b. ADDRESS <i>West Baltimore Community Health Corporation 1701 West Pratt Street, Baltimore, Md. 21223</i>		23c. DATE SIGNED <i>10/6/87</i>	
23d. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23e. DATE <i>10-10-87</i>		23f. NAME OF CEMETERY OR CREMATORY <i>ST. MARY'S</i>		23g. LOCATION CITY OR TOWN COUNTY STATE <i>NEWPORT CHARLES MD.</i>	
24. FUNERAL DIRECTOR NAME <i>THORNTON FUNERAL HOME</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 13 1987</i>			
25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>							

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28332  
2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR 10/ 2/ 19 87 7b. HOUR 4:15 P M

FOR STATE REGISTRAR  
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mildred Cornelia Cole

3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR Apr. 11 1909 78 YRS. 6. AGE (IN YEARS LAST BIRTHDAY) 7. DATE OF BIRTH MONTH DAY YEAR 10/ 2/ 19 87 7c. DATE PRONOUNCED DEAD 10/ 2/ 19 87 7d. HOUR 4:15 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.

10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5501 Key Ave. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Cashier 12b. KIND OF BUSINESS OR INDUSTRY Insurance

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS 208 Brackenwood Ct., 21204

14. FATHER'S NAME FIRST MIDDLE LAST Hugo George Buehner 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Cornelia Lenhardt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 212-16-2496 17. INFORMANT ADDRESS Bette Lou Clark, 208 Brackenwood Ct., 21093

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

DUETO, OR AS A CONSEQUENCE OF (b) DUETO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

Alzheimer's Disease

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Charles P. Kokes, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10/5/87

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation 23b. DATE 10/5/87 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.

24. FUNERAL DIRECTOR NAME Martin D. Lawson 25a. DATE REC'D. BY REGISTRAR OCT 06 1987 25b. REGISTRAR'S SIGNATURE John Davidson

Martin D. Lawson, 10 W. Padonia Rd., 21093

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 10-1, 10-2, 10-3, 10-4, 10-5, 10-6, 10-7, 10-8, 10-9, 10-10, 10-11, 10-12, 10-13, 10-14, 10-15, 10-16, 10-17, 10-18, 10-19, 10-20, 10-21, 10-22, 10-23, 10-24, 10-25, 10-26, 10-27, 10-28, 10-29, 10-30, 10-31, 10-32, 10-33, 10-34, 10-35, 10-36, 10-37, 10-38, 10-39, 10-40, 10-41, 10-42, 10-43, 10-44, 10-45, 10-46, 10-47, 10-48, 10-49, 10-50, 10-51, 10-52, 10-53, 10-54, 10-55, 10-56, 10-57, 10-58, 10-59, 10-60, 10-61, 10-62, 10-63, 10-64, 10-65, 10-66, 10-67, 10-68, 10-69, 10-70, 10-71, 10-72, 10-73, 10-74, 10-75, 10-76, 10-77, 10-78, 10-79, 10-80, 10-81, 10-82, 10-83, 10-84, 10-85, 10-86, 10-87, 10-88, 10-89, 10-90, 10-91, 10-92, 10-93, 10-94, 10-95, 10-96, 10-97, 10-98, 10-99, 10-100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 10-1, 10-2, 10-3, 10-4, 10-5, 10-6, 10-7, 10-8, 10-9, 10-10, 10-11, 10-12, 10-13, 10-14, 10-15, 10-16, 10-17, 10-18, 10-19, 10-20, 10-21, 10-22, 10-23, 10-24, 10-25, 10-26, 10-27, 10-28, 10-29, 10-30, 10-31, 10-32, 10-33, 10-34, 10-35, 10-36, 10-37, 10-38, 10-39, 10-40, 10-41, 10-42, 10-43, 10-44, 10-45, 10-46, 10-47, 10-48, 10-49, 10-50, 10-51, 10-52, 10-53, 10-54, 10-55, 10-56, 10-57, 10-58, 10-59, 10-60, 10-61, 10-62, 10-63, 10-64, 10-65, 10-66, 10-67, 10-68, 10-69, 10-70, 10-71, 10-72, 10-73, 10-74, 10-75, 10-76, 10-77, 10-78, 10-79, 10-80, 10-81, 10-82, 10-83, 10-84, 10-85, 10-86, 10-87, 10-88, 10-89, 10-90, 10-91, 10-92, 10-93, 10-94, 10-95, 10-96, 10-97, 10-98, 10-99, 10-100. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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UNITED STATES DEPARTMENT OF JUSTICE

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXAMINE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR					
WILLIAM A. COLEMAN								9-27-87		<input checked="" type="checkbox"/>		9		27		87							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
Male		Cauc.		11-15-28		58 YRS.		MONTHS		DAYS		HOURS		MIN.		9		27		11:30a			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Mass.				USA								Baltimore City MD											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore				3609 Pulaski Hwy.				Carpenter				Local 101											
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS							
Md.								Balto.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				3601 Pulaski Highway 21224							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
Dennis Coleman				Mary McCormick																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
no				212-24-9543				John Coleman				Marlton, N.J. 08053 44 Radnor Blvd											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) <u>Gastrointestinal bleeding</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) <u>cirrhosis of liver</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c) <u>alcoholism</u>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?							
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>Margaret A. Korell</u> M.D. Assistant MEDICAL EXAMINER																DATE SIGNED 9-28-87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
Margarita A. Korell, M.D.				111 Penn Street																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Cremation				9-30-87				Security Process				Balto., Md.											
24. FUNERAL DIRECTOR																25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213																OCT 2 1987				Julia Davidson-Rodgers			



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO "HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with in 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified and advised.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1 DECEASED NAME FIRST MIDDLE LAST Theodore L. Collier				2a. DATE OF DEATH MONTH DAY YEAR October 19, 1987				2b. HOUR 12:17			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 10, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b KIND OF BUSINESS OR INDUSTRY Martin's			
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Edgemere		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 7000 North Point Road 21219			
14 FATHER'S NAME FIRST MIDDLE LAST Theodore L. Collier				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna M. Hasse							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-03-4113		17 INFORMANT ADDRESS Isabelle Collier 7000 North Point Road							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bleeding esophageal varices</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Clifford S. Mitchell</u> MD						DEGREE MD			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Clifford S. Mitchell</u>						22e ADDRESS <u>FSK MC</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-23-87		23c NAME OF CEMETERY OR CREMATORY Oak Lawn		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24 FUNERAL DIRECTOR NAME		Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE <u>Julia J. Anderson-Landree</u>			



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SEAL NO 105 2002

UNITED

WILKINSON





067778 OCT-7-87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Charles		Glenwood		Collins				10-1-		19		87				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	White	Jan 27, 1926		61 YRS.						10-1-87		19		87		P. 9:56 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Pa.		USA				Baltimore City										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		12 S. chester Street		T.V. Repairman													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12 S. Chester Street		21231							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Richard		Rose		Collins		Kuiper											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		219-10-4740		Diana Neice		233 Scotts Manor Dr. 21061											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		chronic alcoholism															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <u>Charles P. Kokes</u>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 10-2-87											
EXAMINER'S NAME (TYPE OR PRINT)		Charles P. Kokes, M.D.		ADDRESS 111 Penn Street, Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Cremation		10-5-1987		Westview Memorial Pk.		Baltimore. Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
JOHN M. WEBER & SONS INC.		401 S. CHESTER ST.		OCT 06 1987		in Theodore R. Rader											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1043. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

087770 OCT-50

20% COTTON FIBER

MADE IN U.S.A.



067981 OCT-87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28530

1. DECEASED NAME (TYPE OR PRINT) EDITH M COLLINS			2a. DATE OF DEATH MONTH DAY YEAR 10 2 87			2b. HOUR 11:08 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12. 10. 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria Superv.	
12b. KIND OF BUSINESS OR INDUSTRY Hospital							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY 13c. CITY OR TOWN Baltimore							
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2106 Ramsey Str. Baltimore, Md. 21223					
14. FATHER'S NAME FIRST MIDDLE LAST Harry Carr				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 214-12-1271-A		17. INFORMANT ADDRESS Mrs. Shirley Burch, 2106 Ramsey St. Baltimore, Md. 21223			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urinary Tract Infection DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Decubiti Ulcers Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: GI Bleeding, Senile Dementia, Peripheral Vascular Disease, ASCVD							
19a. DATE OF OPERATION 9/9/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Blake Kutsche		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BLAKE KUTSCHE		22e. ADDRESS ST AGNES HOSP 900 CATON AVE BALTIMORE, MD 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Oct. 5, 1987		23c. NAME OF CEMETERY OR CREMATORY Loudon Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland 21229	
24. FUNERAL DIRECTOR NAME G. Truman Schwab, 5151 Balto. Natl. Pike, Balto. Md.		ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR OCT 07 1987		25b. REGISTRAR'S SIGNATURE Davidson-Rendell	

BP  
DHMH - 16 50M 1/81  
(VRA 15. 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

007501 OCT-93

OCT 04 PM

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

William H. Collins

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR

Oct. 31, 1987

M

3 SEX

Male

4 RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
May 15, 1926

6 AGE (IN YEARS LAST BIRTHDAY)

61

YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

W. Virginia

7b. CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☒

9 BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
1417 Light St. Balto. Md.

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)  
Steel/ Tin

12b. KIND OF BUSINESS OR INDUSTRY

Packer

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland

13b. COUNTY

---

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

1417 Light St. Balto. Md. 21230

14. FATHER'S NAME

Clarence

MIDDLE

----

Collins

15. MOTHER'S MAIDEN NAME

Cleo

MIDDLE

F.

Garten

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)  
No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

233-38-9313

17. INFORMANT

ADDRESS

Md. 21227

Mr. Roger D. Collins, 3312 Bero Rd. Balto

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute myocardial infarction

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

24 hrs

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

Hypertensive cardiovascular disease

Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22. I certify that (I) (this hospital) attended the deceased from 8/5 19 83 to 10/31 19 87 that (I) (we) lost saw the deceased alive on 3/5 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Louis E. Grenzer

DEGREE

M.D.

ATTENDING PHYSICIAN ☒

MEDICAL DIRECTOR ☐

STAFF PHYSICIAN ☐

22c. DATE SIGNED

11/2/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Louis E. Grenzer

22e. ADDRESS

1101 N.C. Ave + St B. Ht. md 21202

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

11/3/87

23c. NAME OF CEMETERY OR CREMATORY

Crestlawn Mem. Gard

23d. LOCATION

CITY OR TOWN

Howard Co. Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Balto. Md. 21230

ADDRESS

McCully Funeral Home, 130 E. Fort Ave.

25a. DATE REC'D. BY REGISTRAR

NOV 3 1987

25b. REGISTRAR'S SIGNATURE

Julia F. [Signature]

070783 NOV

5

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

050783 NOV-4-61



WILLY WILLY  
100% COTTON FIBER

NOV 2 1961

069176 OCT 20 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM HENRY COLLINS, SR.			2a. DATE OF DEATH MONTH DAY YEAR 10 14 87		2b. HOUR 10:20AM
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 3 7 1898		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1515 Ramsay Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Fitter	12b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1515 Ramsay Street 21223
14. FATHER'S NAME FIRST MIDDLE LAST John Wesley Collins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Stiner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 705-05-2037		17. INFORMANT ADDRESS Marlene M. Collins 1515 Ramsay St. 21223	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory arrest.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Metastatic adenocarcinoma of colon.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

Anemia.

19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) —	21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — —	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/13/1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE K. Dang	DEGREE —	22c. DATE SIGNED 10/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. Dang	22e. ADDRESS 3455, Wilkens Ave, 21229		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/16/87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25. DATE REGD. BY REGISTRAR OCT 16 1987	26. REGISTRAR'S SIGNATURE Julia Anderson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

000100 000100

000100 000100

000100 000100

000100 000100



067785 OCT - 7 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 8 5 3 9

1. DECEASED NAME (TYPE OR PRINT) <b>BOONIE ELIZABETH COMBS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 3 87</b>		2b. HOUR <b>8:30 PM</b>
3 SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 5 47</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Records Medical</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>Fredrick</b>	13c. CITY OR TOWN <b>Mt. Airy</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William R. Unglesbee</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth E. Bloom</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT ADDRESS <b>Stephen Combs Mt. Airy, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC BREAST CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 1/2 yrs.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>—</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/1</b> , 19 <b>87</b> , to <b>10/3</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/3</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <b>Peter Cenehan M.D.</b>		DEGREE		22c. DATE SIGNED <b>10/3/87.</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Peter Cenehan M.D.</b>		22e. ADDRESS <b>22 S. Greene St., Baltimore, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>		23b. DATE <b>10-7-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marriottsville Howard Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry W. Haight Sykesville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 06 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Frederick R. Rader</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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CORDONUMINOUS PICTURE

METASTATIC BREAST CARCINOMA

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69607 OCT 23 1987

FOR STATE REGISTRAR		Item 5a-film G632 per Funeral Home 10-21-87 RC		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SUSIE B. CONLEY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10 16 87</b>		2b. HOUR <b>M</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>9 10 1889</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>98</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3908 Chatham Road</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>SCHOOL SYSTEM</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>CHESTER BOYER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SIDNEY TALIAFERRO</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>220-30-5677</b>	
17 INFORMANT <b>John &amp; Muriel Carter</b>		ADDRESS <b>Maryland 21207</b>		18. STREET ADDRESS / ZIP CODE <b>3908 Chatham Rd. Baltimore, Md. 21207</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic Ht Dis; decamp 15 yrs</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerosis</b> 30 yrs							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 MIN</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>July 18</b> , 19 <b>73</b> , to <b>Sept. 25</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>9-25</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Jonas H. Cohen</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/16/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jonas H. Cohen M.D.</b>		22e ADDRESS <b>6702 Park Hgts. Ave. Md. 21215</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>10/21/1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEMORIAL PARK</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 19 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John R. ...</b>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT) <b>Laura R. Conway</b>			2a DATE OF DEATH MONTH DAY YEAR <b>October 12, 1987</b>		2b HOUR <b>10:10P</b> M
3 SEX <b>Female</b>	4 RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 30 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b KIND OF BUSINESS OR INDUSTRY <b>PVT. FAMILY</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>11 W. 20th St. Apt. 3-G 21218</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Herbert Collett</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca Pratt</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> <b>No</b>		16b SOCIAL SECURITY NO. <b>220-03-9996</b>		17 INFORMANT ADDRESS <b>Morris Conway 11 W. 20th St. Baltimore, MD</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a DATE OF OPERATION <b>October 2, 1987</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene of above knee</b> <b>Amputation stump</b>		20a AUTOPSY? <b>YES</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (x) (this hospital) attended the deceased from <b>September 24, 19 87</b> , to <b>October 12, 19 87</b> , that (x) (we) lost the deceased alive on <b>October 12, 19 87</b> , and that in (y) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (not) touch the body after death.					
22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) <b>Stephen L. Huhn, M.D.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/13/87</b>	
22e ADDRESS <b>c/o Maryland General Hospital</b>		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>17 Oct 87</b>	23c NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Veteran Cem.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Owings Mills, MD</b>	
24 FUNERAL DIRECTOR NAME <b>Nutter Funeral Homes, Inc. 2501 Gwynnns Falls Pkwy</b>		24a DATE REC'D BY REGISTRAR <b>OCT 19 1987</b>		24b REGISTRAR'S SIGNATURE <b>J. R. [Signature]</b>	

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28542

1. DECEASED NAME (TYPE OR PRINT) Elmer H. Cook Sr.			2a. DATE OF DEATH MONTH DAY YEAR October 4, 1987		2b. HOUR 4:45 AM
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR August 6, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Hardware Store
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Edgemere	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence B. Cook		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vernia M. Truitt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-07-3965		17. INFORMANT ADDRESS Elva M. Cook 9100 North Point Road 21219	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> , 19 <u>87</u> , to <u>10/14</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>10/14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Amelia M. no</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MA				22e. ADDRESS Francis Scott Key Medical Center 4940 Eastern Ave	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-7-87		23c. NAME OF CEMETERY OR CREMATORY Moreland	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR OCT 06 1987		25b. REGISTRAR'S SIGNATURE <u>Law Davidson-Randall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit is removed from carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, then the local examiner must be notified and a copy of the report must be attached to this certificate.)

HP  
DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EMMA Louise COOK</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10 18 87</b>		2b. HOUR <b>3:25 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 1, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Saint Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Hatmaker</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS <b>2800 Linwood Ave., 21234</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Joseph Cook, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Louise Craig</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-07-1950</b>	17. INFORMANT ADDRESS <b>Balto., Md. 21225</b> <b>Emma L. Kilmon 4 W. Second Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: _____				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>10/17</b> , 19 <b>87</b> , to <b>10/18</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/18</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Louis A. Salas M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10/18/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Louis A. Salas M.D.</b>		22e. ADDRESS <b>900 S. CATON AVE.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10/21/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, A.A. Co., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes</b>		ADDRESS <b>237 E. Patapsco Ave., Balto., Md. 21225</b>		25. DATE RECEIVED BY REGISTRAR <b>OCT 20 1987</b>

089342 015181

RECEIVED  
OCT 10 1964

U.S. AIR FORCE

WALLINGFORD

OCT 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Avon Cooper			2a. DATE OF DEATH MONTH DAY YEAR 10/24/87		2b. HOUR M	
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 2 2 1923		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.		
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Cooper			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WILL		17. INFORMANT ADDRESS 21216 Mrs. Alice Brown 2405 Westwood Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of the Lung</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>Years</u> <u>Years</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1 - 9</u> , 19 <u>84</u> , to <u>8 - 10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8 - 10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Dr. Larry S. Perry</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. LARRY S. PERRY, MD.				22e. ADDRESS 107-109 E. Saratoga St, Balto, MD 21202		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/30/87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.
24. FUNERAL DIRECTOR NAME James A. Morton & Sons 1701 Laurens St.				25a. DATE REC'D. BY REGISTRAR OCT 27 1987		
25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>						

BP

010531 021503

070967 NOV - 87

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

28543

REG. NO.

1- FOR  
STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a DATE KNOWN OF DEATH  
ESTIMATED  
MONTH DAY YEAR HOUR  
☒ 10-31 19 87

3 SEX

4 RACE

5 DATE OF BIRTH  
MONTH DAY YEAR6 AGE (IN YEARS)  
LAST BIRTHDAYIF UNDER 1 YR.  
MONTHS DAYSIF UNDER 24 HRS.  
HOURS MIN.2c DATE PRONOUNCED DEAD  
MONTH DAY YEAR

10-31 1987

2d HOUR  
5:55A

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b CITIZEN OF WHAT COUNTRY?

8 MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Balto., Md.

USA

Baltimore City

10 CITY OR TOWN OF DEATH

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

13b COUNTY

13c CITY OR TOWN

13d INSIDE CITY LIMITS?  
YES ☒ NO ☐

13e STREET ADDRESS

734 W. Fayette Street

14 FATHER'S NAME  
FIRST MIDDLE LAST

Bernard William

Cooper

15 MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST

Effie Mae Leake

16a WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)16b SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

217-86-2713

17 INFORMANT

ADDRESS

No

Effie M. Cooper

734 W. Fayette

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Perforating gunshot wound of head

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?  
YES ☒ NO ☐21a EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH21b TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

5:45AM 10-31-87

Subject shot.

21d INJURY OCCURRED  
WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f LOCATION  
STREET CITY OR TOWN COUNTY STATE

alley

200 N. Carrollton Avenue, Baltimore City, MD

22a I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

TITLE (SPECIFY)

M.D. Deputy Chief

DATE SIGNED 10-31-87

ACTUAL SIGNATURE

EXAMINER'S NAME (TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION  
CITY OR TOWN COUNTY STATE

Burial

11-05-87

Mt. Zion Cemetery

Baltimore, Maryland

24 FUNERAL DIRECTOR  
NAME ADDRESS

25a DATE REC'D. BY REGISTRAR

25b REGISTRAR'S SIGNATURE

Brown/Thompson Funeral Home P.O. Box 445

NOV 5 1987

Julia Decker-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

07/B4  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

070067 MAY-007



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, LINE 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		REG. NO.		2a. DATE KNOWN OF DEATH		2b. HOUR	
Earl				Cooper				2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE KNOWN OF DEATH		2b. HOUR	
MALE		B		8/23/45		41 YRS.		10/ 3/19 87		8:40 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
NASH CO., N.C.		USA		WIDOWED		Baltimore City,					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Deaton Medical Center		K&K TRASH CO.		TRASH REMOV					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD				BALTO.		YES X NO		2801 Boardman Ave. 21215			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
EARNEST COOPER		MARY TAYLOR									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		240 68 1800		MARY TAYLOR		RT.2 WHITKERS N. CAR.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. TIME OF INJURY		20. AUTOPSY?							
PART I DEATH WAS CAUSED BY:		21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
IMMEDIATE CAUSE (a) Head injuries with complications		21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
7311		21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
DUE TO, OR AS A CONSEQUENCE OF		21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
(b)		21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
DUE TO, OR AS A CONSEQUENCE OF		21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
(c)		21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
19a. DATE OF OPERATION		21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED					
21a. TIME OF INJURY		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c.							



30% COTTON FIBER

DMB WFF-TH





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

067734 OCT 7 1987

1. DECEASED NAME (TYPE OR PRINT) Grace M. Cooper			2a. DATE OF DEATH MONTH DAY YEAR 10 / 3 / 87		2b. HOUR 0250M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11 / 8 / 32	6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of Md Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TECHNICIAN		12b. KIND OF BUSINESS OR INDUSTRY MUNITIONS
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. CITY OR TOWN Harford	13c. STREET ADDRESS / ZIP CODE 3314 Dublin Road 21034		
14. FATHER'S NAME FIRST MIDDLE LAST PAUL W. KRICK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA M. TAYLOR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 162-26-2613	17. INFORMANT ADDRESS 3314 DUBLIN ROAD CLIFFORD M. COOPER, DARLINGTON, MD.		

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Metastatic Melanoma

DUE TO, OR AS A CONSEQUENCE OF

(c) Meningitis - Pseudomonas

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION 7/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Metastatic Melanoma Brain	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death.			
22b. SIGNATURE John Hughes	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/3/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Hughes		22e. ADDRESS Univ of Md Hosp, Div of Neurosurgery	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 6, 1987	23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Aldino Harford Maryland
24. FUNERAL DIRECTOR NAME Harkins Funeral Home, Inc., 600 Main St., Delta, PA		25a. DATE REC'D. BY REGISTRAR OCT 06 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

087730 467720 785-700

070796 NOV 17 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>COOPER, REBECCA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-29-87</b>			2b. HOUR <b>6:55P</b>	
3. SEX <b>F</b>	4. RACE <b>BZ</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>01-01-10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNEMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MACK CREW</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GEITHA RICHARDSON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>212-16-6668</b>		17. INFORMANT ADDRESS <b>DENISE COOPER 1224 ROSSITER AVENUE APT. 1D 21239</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR DISEASE</b> years DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PNEUMONIA</b> 2 wks DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-16-87</b> to <b>10-29-87</b> , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on <b>10-29-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) <input checked="" type="checkbox"/> did (did not) view the body after death.							
22b. SIGNATURE <b>C. J. Nesbitt MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/29/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CJNESBITT</b>		22e. ADDRESS <b>MERCY HOSPITAL 301 ST PAUL PL BALT, MD 21202</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/4/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ANNE ARUNDEL CO. MD</b>	
24. FUNERAL DIRECTOR NAME <b>WM. C. MARCH F/H 1101 E. NORTH AVENUE</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 03 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Friedman-Randall</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21204

BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000 COLLECTION

1990-1999

2000 COLLECTION

1990-1999

068305 OCT 13 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 8 5 4 9

REG. NO.

1- FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(PRINT)

FIRST

MIDDLE

LAST

JAMES

COPE

2a. DATE KNOWN OF DEATH  
ESTIMATED ☒ MONTH DAY YEAR  
10 6 19 872b. HOUR  
10:00 P.M.

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

10 27 04

6. AGE (IN YEARS)

82 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN

2c. DATE PRONOUNCED DEAD

10 6 19 87

2d. HOUR  
10:00 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Italy

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

University Hospital (STU)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Executive

12b. KIND OF BUSINESS OR INDUSTRY

Public Relation

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY  
Talbot13c. CITY OR TOWN  
Easton13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐

13e. STREET ADDRESS

233 Brookwood Avenue 21601

14. FATHER'S NAME

James

MIDDLE  
Canby BiddleLAST  
Cope

15. MOTHER'S MAIDEN NAME

Emilia

MIDDLE

LAST  
Stefania

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)  
no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

578-01-4911

17. INFORMANT

ADDRESS

Martha L. Cope 233 Brookwood Easton MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a). Head and neck injuries

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR ~~XX~~ MONTH DAY YEAR  
4:36 P.M. 10-6- 1987

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Driver of auto/auto collision.

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

road

21f. LOCATION

Easton Pkwy. &amp; Centreville Rd., Talbot

CITY OR TOWN

COUNTY

STATE

Easton

22a. I certify that I took charge of the remains described above, held on

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from: Natural cause ☐Accident ☒Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL  
SIGNATURE

TITLE (SPECIFY)

Deputy Chief

M.D.

MEDICAL EXAMINER

DATE SIGNED 10-7-87

EXAMINER'S NAME  
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS

111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Cremation

23b. DATE

10/8/87

23c. NAME OF CEMETERY OR CREMATORY

Salisbury Crematory

23d. LOCATION

Salisbury

Wicomico

STATE  
MD

24. FUNERAL DIRECTOR

NAME

Newnam Funeral Home

ADDRESS

Easton, Maryland

25a. DATE REC'D. BY REGISTRAR

OCT 9 1987

25b. REGISTRAR'S SIGNATURE

Julia Swider-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

060202 OCT 13 87

20% COTTON FIBER

100% COTTON

100% COTTON



100% COTTON

060202 OCT 13 87

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit and page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Cora M. Corbin</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>10 07 87</i>		2b. HOUR <i>12:40AM</i>	
3. SEX <i>Female</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>09 28 1892</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>95 yrs.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Deaton Hospital and Medical Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>UNKNOWN</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>UNKNOWN</i>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE CITY</i>	13c. CITY OR TOWN <i>BALTIMORE</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>LITTLETON (DOANE)</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNIE FLEMING</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>UNKNOWN</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>215-16-1499A</i>	17. INFORMANT ADDRESS <i>CHART - DEATON NURSING HOME</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO PULMONARY ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CONGESTIVE HEART FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>UROSEPSIS</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9/30</i> , 19 <i>87</i> , to <i>10/7</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>10/7</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Basil E. Chryssos M.D.</i>		DEGREE		22c. DATE SIGNED <i>10/7/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BASIL E. CHRYSOS MD</i>		22e. ADDRESS <i>SOUTH BALTIMORE General Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>10/10/87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Memorial Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Arbutus Md</i>	
24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H West</i>		ADDRESS <i>4300 Wabash Avenue</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 8 1987</i>	25b. REGISTRAR'S SIGNATURE <i>Julia Dandridge-Randall</i>

068221 OCT - 9 87

2 8 5 5 0



088551 OCT-94

10/11/94

10/11/94

10/11/94



069488 OCT 28-87

OR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SUSIE May CORBITT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 14 87</b>		2b. HOUR <b>3A M</b>			
3. SEX <b>Female ♀</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 30 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FSK MC</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Claude Pierce</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Adena Louise Wiggins</b>		16. ADDRESS <b>605 S. Newkirk Street 21224</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-10-2112</b>		17. INFORMANT ADDRESS <b>Louis Corbitt, 962 Princeton Terrace Glen Burnie, Md. 21061</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>FA</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>10-14-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FA WFF</b>				22e. ADDRESS <b>FSK MC</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-16-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Ann S. Matthews, Matthews Funeral Home</b> <b>3021 Eastern Ave., Baltimore, Md. 21224</b>						25. DATE REC'D. BY REGISTRAR <b>OCT 21 1987</b>		
26. REGISTRAR'S SIGNATURE <b>Julia Dutton-Rudolph</b>								

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of page 1 of 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10 05 120 80 1000

CHARLES DOWDY

BOX COLUMBIA

69741 OCT 26 1987

FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28552

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
JOHN HENRY CORLEY

2. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 10-17-87

3. SEX MALE 4. RACE BLACK 5. DATE OF BIRTH MONTH DAY YEAR 6 23 27 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.

9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1800 Pressman Street

12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN 13. KIND OF BUSINESS OR INDUSTRY N/A

13a. STATE MD 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 1800 PRESSTMAN ST. 21217

14. FATHER'S NAME FIRST MIDDLE LAST EDD CORLEY 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE MIMMS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 293-07-5549 17. INFORMANT ADDRESS RACHEL DORSEY 1800 PRESSTMAN ST.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cirrhosis of liver  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
(b) chronic alcoholism  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? (HEAD ONLY) YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above (HEAD ONLY) Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE (Signature) TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-18-87

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 10/24/87 23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM. 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD

24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MAECH F/H 1101 E. NORTH AVENUE 25a. DATE REC'D. BY REGISTRAR OCT 23 1987 25b. REGISTRAR'S SIGNATURE (Signature)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

001 201 1 1 1 0 0



001 201 1 1 1 0 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>RICHARD L. CORNISH SR</b>			7a. DATE OF DEATH MONTH <b>10</b> DAY <b>29</b> YEAR <b>87</b>			7b. HOUR <b>12<sup>30</sup></b> AM					
3. SEX <b>male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>22</b> YEAR <b>50</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>37</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of MD Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b></b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Social Security</b>		
13a. STATE <b>MD</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Baltimore City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>718 Brune St 21201</b>			
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b></b> LAST <b>CORNISH</b>				15. MOTHER'S MAIDEN NAME FIRST <b>LOTTIE</b> MIDDLE <b></b> LAST <b>CORNISH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>219-52-3188</b>		17. INFORMANT ADDRESS <b>Dorothy L. Cornish 718 Brune St 21201</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic cholangiocarcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-5 minutes</b> <b>2 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> 19 <b>87</b> to <b>10/29</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/28</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Nadine B Semer MD</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/29/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Nadine B Semer</b>						22e. ADDRESS <b>22 S Greene St Balto 21218</b>					
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>BURIAL</b>				23b. DATE <b>11-02-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARRISON FOREST</b>		23d. LOCATION CITY OR TOWN <b>Owings Mills</b> COUNTY <b>M.D.</b>			
24. FUNERAL DIRECTOR NAME <b>Redd Funeral Home</b> ADDRESS <b>5209 York Rd</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John T. ...</b>			

BP



068791 OCT 16 87

Item 18a, 20, 21a, b, c, d, e, f, 22a

G632 dw

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST DAVID		MIDDLE LEROY		LAST COTTOM (COTTON)		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 10 10 19 87		2b. HOUR M 10:5 PM	
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 8 23 1952		6. AGE (IN YEARS) LAST BIRTHDAY 35 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 10 19 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2825 Gatehouse Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Inc Peak Construction			
13a. STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2825 Gatehouse Drive 21207			
14. FATHER'S NAME FIRST MIDDLE LAST Herbert Cottom		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cornelius Gibbs		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-58-8926		17. INFORMANT ADDRESS Joyce Y. Cottom 2825 Gatehouse Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotic intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-10 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject used drugs							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2825 Gatehouse Drive Baltimore, MD							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 10-11-87					
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.		ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/16/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet		23d. LOCATION CITY OR TOWN COUNTY Owings Mills MD					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West				ADDRESS 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR OCT 15 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Danderson-Randall</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM WM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25MDHMH - 17  
(VR A15 ME (5))



78 61 730 1 2 7 8 6 0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. (Important: If item 21 is marked or item 18 shows any injury, or other traumatic condition, a medical examiner must be notified at once.)

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>HENRY COURTNEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 12 87</b>			2b. HOUR <b>6P</b>					
3. SEX <b>M</b>		4. RACE <b>B 2</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 12 21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIV of MD HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BETTERMAN STEEL</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1109 RIGGS AVE 21217</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William COURTNEY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EDITH BLEVINS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212 24 8747</b>		17. INFORMANT <b>DAUGHTER RUBY COURTNEY</b>		ADDRESS <b>1302 Hylan A</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RE METASTATIC ADENOCARCINOMA LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>MALIGNANT PLEURAL EFFUSIONS</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <b>10/3</b> <b>1987</b> to <b>10/12</b> <b>1987</b> , that (1) <input checked="" type="radio"/> I saw the deceased after death on <b>10/12</b> <b>1987</b> , and that in (my) <input checked="" type="radio"/> own opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not see the body after death.)											
22b. SIGNATURE <b>Glenn D Gilmer</b>			DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>10/12/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Glenn D Gilmer</b>			22e. ADDRESS <b>22 S. GREEN ST BALTO, 21201</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10/19/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RUSSELLVILLE CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RUSSELLVILLE TN</b>				
24. FUNERAL DIRECTOR NAME <b>WM. C. MARCH F/H, INC.</b>					ADDRESS <b>1101 E. NORTH AVENUE</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 15 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Denison-Randall</b>		

BP


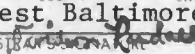
68713 Oct 18 61

Handwritten notes on lined paper, including the word "X" and various illegible scribbles.

70321 OCT 30 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANK C. CRAFTON</b>										2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 28 87</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 08 29</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>57 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10 28 87</b>		2d. HOUR AM PM <b>6:10 AM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bricklayer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1213 Light Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elzy Crafton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Heckler</b>		17. INFORMANT ADDRESS <b>Mr. Stanley E. Kohlhepp 21215 4028 Lewiston Ave. Baltimore, MD.</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>1951-1959</b>		16c. SOCIAL SECURITY NO. <b>217-26-2973</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Cirrhosis of the liver</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Deputy Chief</b>		DATE SIGNED <b>10-28-87</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St., Balto., MD 21201</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/30/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Garrison Forest, Baltimore MD.</b>					
24. FUNERAL DIRECTOR NAME <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>		25a. DATE OF DEATH <b>OCT 29 1987</b>		25b. REGISTRAR SIGNATURE 					

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

1000 1000 1000



1000 1000 1000

Item 18a, 20, 22a, G632 10-30-87 dw STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28557  
 REG. NO.

FOR STATE REGISTRAR per med exam

069110 OCT 20 1987

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			3. MONTH DAY YEAR			7b. HOUR		
DARRYL J. CRAWFORD			10-7-87			19			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
MALE	BLACK	7 5 1965	22 YRS.					10-7-87 19		8:02PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
New York, N. Y.			U. S. A.						Baltimore City MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS		
Baltimore			University Hospital			Attendant			Harry M. Stevens		
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS			13d. INSIDE CITY LIMITS?		
New York			New York, N.Y.			New York 10037			YES <input type="checkbox"/> NO <input type="checkbox"/> 1980 Park Ave. New York, 99999		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
James Crawford						Daiselle Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)						16b. SOCIAL SECURITY NO.			17. INFORMANT		
NO.						075-62-3540			Mr. James Crawford		
						ADDRESS			New York, N. Y. 1980 Park Avenue, 10037		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Hypertensive cardiomyopathy</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
								CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Margarita A. Korell</u> M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 10-8-87			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.								ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
Burial				10/14/87		Rosehill Cemetery				Linden, New Jersey	
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216								OCT 19 1987		<u>David A. Jones</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVING PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

DHMH - 17  
(VR A15 ME (5))

BP 822

000110 011000

20% COTTON FIBER

DAVID L. WILSON







Check  
CVA  
brought into report

10/10/50

10/10/50



068968 OCT 20 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28559

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SHEILA CRITTERTON</b>				7a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <b>10-17-87</b>				7b. HOUR <b>2:40a</b>	
3. SEX <b>F</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 13 55</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>32</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>10-17-87</b>		7d. HOUR <b>2:40a</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Liberty Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3000 Wolcott Ave. 21216</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Russell Critterton</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Aretha Critterton</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>220 76 4406</b>		17. INFORMANT ADDRESS <b>Mrs. Aretha Critterton 3000 Wolcott</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Down's Syndrome</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Margareta A. Korell</i>				TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>10-17-87</b>		M.D. MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/22/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Men. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Jas. A. Morton &amp; Sons</b>				ADDRESS <b>1701 Laurens St.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 19 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM WM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

000008 OCT 30 1961

ADDITIONAL INFORMATION

UNITED STATES AIR FORCE



100-100000-100000

69395 OCT 22 1987

FOR  
STATE  
REGISTRARItem #12a Film G632  
per funeral home 10/21/87STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FRANCES CROCKER</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>16</b> YEAR <b>87</b>			2b. HOUR <b>2 20</b> P.M.				
1. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>15</b> YEAR <b>12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Liberty Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST <b>Jerry</b> MIDDLE <b>C.</b> LAST <b>Crocker</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Maggie</b> MIDDLE <b>Warren</b> LAST <b>Warren</b>			13e. STREET ADDRESS / ZIP CODE <b>3234 Sequoia Ave 21215</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>231-14-3601</b>		17. INFORMANT <b>Bertha Williams</b>				ADDRESS <b>3234 Sequoia Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>RENAL FAILURE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <b>SCALDED SKIN SYNDROME; PNEUMONIA; Uncontrolled D/H</b>										
9a. DATE OF OPERATION			19a. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/8</b> 19 <b>87</b> to <b>10/16</b> 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>10/16</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Arbutus WORTH</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/16/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARBUS WORTH</b>			22e. ADDRESS <b>LIBERTY MED. CENTER</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/22/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus Md</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H West 4300 Wabash Avenue</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 20 1987</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

0936 6732 888

071044 NOV

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28501  
2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ 10/ 29/ 19 87 2b. HOUR 10:20 P M

1- FOR STATE REGISTRAR  
DECEASED NAME (TYPE OR PRINT)

FIRST

MIDDLE

LAST

Eric

C.

Crosby

1. SEX  
MALE4. RACE  
BLACK5. DATE OF BIRTH  
MONTH DAY YEAR  
NOV. 3, 19676. AGE (IN YEARS)  
LAST BIRTHDAY  
19 YRS.IF UNDER 1 YR.  
MONTHS DAYS HOURS MIN.  
IF UNDER 24 HRS.7c. DATE PRONOUNCED DEAD  
10/ 29/ 19 877a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
MARYLAND7b. CITIZEN OF WHAT COUNTRY?  
US of A8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City, MD.

10. CITY OR TOWN OF DEATH  
Baltimore11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
2800 Blk. Oakley Ave.12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
BAKER12b. KIND OF BUSINESS OR INDUSTRY  
BAKERY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
MARYLAND

13b. COUNTY

13c. CITY OR TOWN  
BALTIMORE13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐13e. STREET ADDRESS  
2701 OAKLEY AVE., 2121514. FATHER'S NAME  
FIRST MIDDLE LAST  
MILTON15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST  
ANNIE YOUNG16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
NO16b. SOCIAL SECURITY NO.  
217 02 131617. INFORMANT ADDRESS  
MRS. ANNIE CROSBY 2701 OAKLEY AVE., 21215

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Gunshot Wound of Abdomen &amp; Chest

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
10:05PM 10/29/19 8721c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  
subject shot

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
on street21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

2800 Blk. Oakley Ave., Balto. City, Md.

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐.

ACTUAL SIGNATURE

Margie Dore Yell

TITLE (SPECIFY)

M.D. Assistant

MEDICAL EXAMINER

DATE SIGNED

10/30/87

EXAMINER'S NAME (TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS

111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

11/4/87

23c. NAME OF CEMETERY OR CREMATORY

BALTIMORE CEMETERY

23d. LOCATION  
CITY OR TOWN

BALTIMORE

COUNTY

STATE

MD.

24. FUNERAL DIRECTOR

NAME

ADDRESS

LEWIS T. GWYNN 4517 PARK HEIGHTS AVE., 21215

25a. DATE REC'D. BY REGISTRAR

NOV 04 1987

25b. REGISTRAR'S SIGNATURE

Julia Sander-Landess

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THIS CERTIFICATE IS VALID FOR 10 DAYS. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE REMAINS. PAGE 5 SHOULD BE FILED WITHIN 72 HOURS TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSMIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARAH E. CROWDER			2a. DATE OF DEATH MONTH DAY YEAR 10 29 87		2b. HOUR 2 39 M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8 21 21	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2107 Braddish Ave 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Mitchell Simmons		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sweet K. Terrell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-22-8418	17. INFORMANT ADDRESS Capt O. Crowder 2107 Braddish Ave		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST		
DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

CEREBROVASCULAR ACCIDENT

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/28 19 87 to 10/29 19 87 that (I) (we) last saw the deceased alive on 10/28 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Ambacher Woreta	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMBACHER WORETA		22e. ADDRESS LIBERTY MEDICAL CENTER	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/3/87	23c. NAME OF CEMETERY OR CREMATORY King Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West		ADDRESS 4300 Wabash Avenue	25a. DATE REC'D. BY REGISTRAR NOV 02 1987
		25b. REGISTRAR'S SIGNATURE G. B. Borden-Randall	



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28503

1. DECEASED NAME (TYPE OR PRINT) MARY CAMILLA CUMMINGS			2a. DATE OF DEATH MONTH DAY YEAR October 14, 1987		2b. HOUR 1:00A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 6, 1904	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Hamilton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assistant		12b. KIND OF BUSINESS OR INDUSTRY Dress Shop
13a. STATE MD		13b. COUNTY Balto.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 6440 Harford Rd., 21214	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander L. Cummings		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bogue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 14 0175	17. INFORMANT ADDRESS Philomena C. Mahony, Balto., MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Central Cerebrovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Gen ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>72</u> , to <u>present</u> , 19 <u>87</u> , that (we) (I) saw the deceased alive on <u>Oct 13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Raymundo Magno</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Raymundo Magno, MD		22e. ADDRESS 7811 Wise Ave., Balto., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/16/87	23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD	
24. FUNERAL DIRECTOR NAME H.W. Jenkins & Sons Co.		25a. DATE REC'D. BY REGISTRAR OCT 16 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST <u>MATTHE</u> <u>8544</u> <u>CUMMINGS</u>			MONTH DAY YEAR <u>October 2, 1987</u>			<u>12:45<sup>PM</sup></u>		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
<u>M</u>	<u>W</u>	MONTH DAY YEAR <u>10 3 06</u>	<u>50</u> YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
<u>Augusta Ga</u>	<u>USA</u>			<u>Baltimore City</u> MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
<u>Baltimore</u>	<u>Maryland General Hospital</u>			<u>Rx Domestic Air Family</u>				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE			
<u>MD</u>		<u>Baltimore</u>	<u>Baltimore</u>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<u>903 N PARKVIEW ST 21217</u>			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
<u>Donna H CUMMINGE</u>				<u>ROSEBEE MARSHALL</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
<u>NO</u>			<u>220-18-3556</u>		<u>Frank Cummings 903 N PARKVIEW ST</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACUTE RESPIRATORY FAILURE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (X) (this hospital) attended the deceased from <u>August 28, 1987</u> to <u>October 2, 1987</u> , that (X) (we) last saw the deceased alive on <u>October 2, 1987</u> , and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.								
22b. SIGNATURE <u>Michael A. Wilson M.D.</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10-2-87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael A. Wilson M.D.</u>						22e. ADDRESS <u>c/o Maryland General Hospital</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
<u>Burial</u>		<u>10/6/87</u>		<u>45000000</u>		<u>Baltimore, MD</u>		
24. FUNERAL DIRECTOR NAME ADDRESS <u>Blanchard &amp; Phipps 135 N. G. 1st St</u>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>
						<u>OCT 05 1987</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) CARRIE CURETON			20 DATE OF DEATH MONTH DAY YEAR 10/11/87		2b HOUR 6:03 AM
3 SEX F	4 RACE B	5 DATE OF BIRTH MONTH DAY YEAR 09 12 19	6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD		13b CITY OR TOWN BALTIMORE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4314 NORFOLK AVE 21216
14 FATHER'S NAME FIRST MIDDLE LAST Montgomery		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Tinkler			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 213-05-3263D		17 INFORMANT ADDRESS Henrietta Wade 12640 F. Moore	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MALNUTRITION, DECUBITUS FLAP</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>(R) HIP FRACTURE</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>9/7</u> 19 <u>87</u> , to <u>10/11</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/11</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b SIGNATURE D. Rosenthal		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 10/11/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS ROSENTHAL		22e ADDRESS SINAI HOSPITAL			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/16/87		23c NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co MD		24 FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue			
25a DATE REC'D BY REGISTRAR OCT 14 1987		25b REGISTRAR'S SIGNATURE Julia Swickard-Randall			

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1961 OCT 13



067733 OCT-17-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 28500					
1. DECEASED NAME (TYPE OR PRINT) <b>Hugh A. Curley Sr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>10-2-87</b>				2b. HOUR <b>4:30P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-3-1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5713 Edgepark Road-21239</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Operations Dept.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ramsey Scarlett</b>	
13a. STATE <b>MD.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5713 Edgepark Road-21239</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Curley</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Thomas</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-07-6293</b>		17. INFORMANT ADDRESS <b>Katherine M. Curley - 5713 Edgepark Rd. 21239</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>July 2</u> 19 <u>82</u> , to <u>Oct. 2</u> 19 <u>87</u> , that (1) (we) lost saw the deceased alive on <u>March 17</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>David D. Collier MD</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/5/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>10-6-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>John C. Miller, Inc.-6415 Belair Rd.-21206</b>						ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>OCT 06 1987</b>		25b. REGISTRAR'S SIGNATURE <u>Deborah Landale</u>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please reinsert certificate in page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO:

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Ethel Mae CURRY					10	10	87		2240
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
F	Black	MONTH DAY YEAR 11 9 18		68	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
GA	USA			BALTIMORE MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE	SINAI HOSPITAL			Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
MD.		BALTIMORE	BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7401 BEECH AVENUE 21206				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS					
First MIDDLE LAST Elex Mason		First MIDDLE LAST Julie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO		253-22-6783		Allen Curry 7401 Beech Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>BREAST CA WITH METS TO BRAIN</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE			22c. DATE SIGNED		
KENNETH C. RUSS									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
				BELVEDERE AT GREENSPRING BALTO MD 21203					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE	
BURIAL		10/16/87		MD NATIONAL MEM. PK		LAUREL		MD	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE				OCT 15 1987		Julia Devlin-Rudace			

BP

008770 001100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1-81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CARRIE VIRGINIA DAILEY			2a. DATE OF DEATH MONTH DAY YEAR 10 31 87			2b. HOUR M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5/26/12		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Md. <i>Har</i>				13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Pinkney Simms				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Simms			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-2463		17. INFORMANT ADDRESS Columbia John Dailey 8704 Airy Brink La, Md. 21045			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>pump failure</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 28</u> , 19 <u>87</u> , to <u>Oct 31</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Oct 31</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Khaled Ri Kabi</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Khaled Ri Kabi				22e. ADDRESS POOCHATION AVE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/4/87		23c. NAME OF CEMETERY OR CREMATORY Arbutua Park		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md.	
24. FUNERAL DIRECTOR NAME Estep Bros. F.H. 1300 Eutaw Place				25. DATE RECEIVED BY REGISTRAR NOV 5 1987			

28563



FOR  
STATE  
REGISTRAR


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR								
Lucy			Ann			Davenport			10			15			87								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS.								
Female			Black			MONTH DAY YEAR 5 14 1924			63			YRS.			MONTHS DAYS HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH														
Pennsylvania			U. S. A.						Baltimore City MD														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			SCHOOLS								
Baltimore			Caton Home Care Center						Cafeteria Worker			Balto. Co.											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			Maryland 21216		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3017 Poplar Terrace			Baltimore.								
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			MIDDLE			LAST								
Robert			Andrew			Giles			Jettie						Lee								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS														
No.			220--22--2514			Mr. Louis R. Davenport			Baltimore, Md. 21216 3017 Poplar Terrace														

<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I DEATH WAS CAUSED BY:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>CIRRHOSIS OF LIVER</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	DUE TO, OR AS A CONSEQUENCE OF (b) <u>DIABETES MELLITUS</u>	
	DUE TO, OR AS A CONSEQUENCE OF (c) <u>ALCOHOL ABUSE CHRONIC</u>	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

MEDICAL CERTIFICATION	19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A	
	21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK N/A	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A	21f. LOCATION STREET CITY OR TOWN COUNTY STATE MA	
	22. I certify that (if this hospital) attended the deceased from 9/20, 1985, to 9/20, 1985, that (I) (we) last saw the deceased alive on 9/20, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE 	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/15/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. A. WINSTON	22e. ADDRESS 2000 LIBERTY HIGHWAY			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10/21/1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Froest Vet. Cem.</b>	23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>Md.</b>
24. FUNERAL DIRECTOR NAME <b>NUFER FUNERAL HOMES, INC.</b> ADDRESS <b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>		25. DATE RECEIVED BY DECEASED <b>OCT 23 1987</b> 26. REGISTERED SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies #001, #002, #003, #004, #005, #006, #007, #008, #009, #010, #011, #012, #013, #014, #015, #016, #017, #018, #019, #020, #021, #022, #023, #024, #025, #026, #027, #028, #029, #030, #031, #032, #033, #034, #035, #036, #037, #038, #039, #040, #041, #042, #043, #044, #045, #046, #047, #048, #049, #050, #051, #052, #053, #054, #055, #056, #057, #058, #059, #060, #061, #062, #063, #064, #065, #066, #067, #068, #069, #070, #071, #072, #073, #074, #075, #076, #077, #078, #079, #080, #081, #082, #083, #084, #085, #086, #087, #088, #089, #090, #091, #092, #093, #094, #095, #096, #097, #098, #099, #100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132, #133, #134, #135, #136, #137, #138, #139, #140, #141, #142, #143, #144, #145, #146, #147, #148, #149, #150, #151, #152, #153, #154, #155, #156, #157, #158, #159, #160, #161, #162, #163, #164, #165, #166, #167, #168, #169, #170, #171, #172, #173, #174, #175, #176, #177, #178, #179, #180, #181, #182, #183, #184, #185, #186, #187, #188, #189, #190, #191, #192, #193, #194, #195, #196, #197, #198, #199, #200, #201, #202, #203, #204, #205, #206, #207, #208, #209, #210, #211, #212, #213, #214, #215, #216, #217, #218, #219, #220, #221, #222, #223, #224, #225, #226, #227, #228, #229, #230, #231, #232, #233, #234, #235, #236, #237, #238, #239, #240, #241, #242, #243, #244, #245, #246, #247, #248, #249, #250, #251, #252, #253, #254, #255, #256, #257, #258, #259, #260, #261, #262, #263, #264, #265, #266, #267, #268, #269, #270, #271, #272, #273, #274, #275, #276, #277, #278, #279, #280, #281, #282, #283, #284, #285, #286, #287, #288, #289, #290, #291, #292, #293, #294, #295, #296, #297, #298, #299, #300, #301, #302, #303, #304, #305, #306, #307, #308, #309, #310, #311, #312, #313, #314, #315, #316, #317, #318, #319, #320, #321, #322, #323, #324, #325, #326, #327, #328, #329, #330, #331, #332, #333, #334, #335, #336, #337, #338, #339, #340, #341, #342, #343, #344, #345, #346, #347, #348, #349, #350, #351, #352, #353, #354, #355, #356, #357, #358, #359, #360, #361, #362, #363, #364, #365, #366, #367, #368, #369, #370, #371, #372, #373, #374, #375, #376, #377, #378, #379, #380, #381, #382, #383, #384, #385, #386, #387, #388, #389, #390, #391, #392, #393, #394, #395, #396, #397, #398, #399, #400, #401, #402, #403, #404, #405, #406, #407, #408, #409, #410, #411, #412, #413, #414, #415, #416, #417, #418, #419, #420, #421, #422, #423, #424, #425, #426, #427, #428, #429, #430, #431, #432, #433, #434, #435, #436, #437, #438, #439, #440, #441, #442, #443, #444, #445, #446, #447, #448, #449, #450, #451, #452, #453, #454, #455, #456, #457, #458, #459, #460, #461, #462, #463, #464, #465, #466, #467, #468, #469, #470, #471, #472, #473, #474, #475, #476, #477, #478, #479, #480, #481, #482, #483, #484, #485, #486, #487, #488, #489, #490, #491, #492, #493, #494, #495, #496, #497, #498, #499, #500, #501, #502, #503, #504, #505, #506, #507, #508, #509, #510, #511, #512, #513, #514, #515, #516, #517, #518, #519, #520, #521, #522, #523, #524, #525, #526, #527, #528, #529, #530, #531, #532, #533, #534, #535, #536, #537, #538, #539, #540, #541, #542, #543, #544, #545, #546, #547, #548, #549, #550, #551, #552, #553, #554, #555, #556, #557, #558, #559, #560, #561, #562, #563, #564, #565, #566, #567, #568, #569, #570, #571, #572, #573, #574, #575, #576, #577, #578, #579, #580, #581, #582, #583, #584, #585, #586, #587, #588, #589, #590, #591, #592, #593, #594, #595, #596, #597, #598, #599, #600, #601, #602, #603, #604, #605, #606, #607, #608, #609, #610, #611, #612, #613, #614, #615, #616, #617, #618, #619, #620, #621, #622, #623, #624, #625, #626, #627, #628, #629, #630, #631, #632, #633, #634, #635, #636, #637, #638, #639, #640, #641, #642, #643, #644, #645, #646, #647, #648, #649, #650, #651, #652, #653, #654, #655, #656, #657, #658, #659, #660, #661, #662, #663, #664, #665, #666, #667, #668, #669, #670, #671, #672, #673, #674, #675, #676, #677, #678, #679, #680, #681, #682, #683, #684, #685, #686, #687, #688, #689, #690, #691, #692, #693, #694, #695, #696, #697, #698, #699, #700, #701, #702, #703, #704, #705, #706, #707, #708, #709, #710, #711, #712, #713, #714, #715, #716, #717, #718, #719, #720, #721, #722, #723, #724, #725, #726, #727, #728, #729, #730, #731, #732, #733, #734, #735, #736, #737, #738, #739, #740, #741, #742, #743, #744, #745, #746, #747, #748, #749, #750, #751, #752, #753, #754, #755, #756, #757, #758, #759, #760, #761, #762, #763, #764, #765, #766, #767, #768, #769, #770, #771, #772, #773, #774, #775, #776, #777, #778, #779, #780, #781, #782, #783, #784, #785, #786, #787, #788, #789, #790, #791, #792, #793, #794, #795, #796, #797, #798, #799, #800, #801, #802, #803, #804, #805, #806, #807, #808, #809, #





068864 OCT 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 3 is to be filed with the local health department. Page 4 is to be filed with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Leon David</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-10-87</b>			2b. HOUR <b>10:25 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-27-1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Levindale</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PROPRIETOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CHEMICAL CO.</b>		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>APT. 815 7 SLADE AVE BALTO., MD 21208</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM MEYER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LILLIAN KLAFF</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-14-0552</b>		17. INFORMANT ADDRESS <b>MRS. TILLYE DAVID APT. 815 7 SLADE AVE. BALTO., MD 21208</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from <b>4/11</b> , 19 <b>68</b> , to <b>10/10</b> , 19 <b>87</b> , that (we) last saw the deceased alive on <b>10/10</b> , 19 <b>87</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.										
22b. SIGNATURE <b>Leon</b>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10/11/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELLITA O. KIN</b>			22e. ADDRESS <b>LEVINDALE HEBREW GERIATRIC CENTER + HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>OCT. 12, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>			ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			25a. DATE REC'D. BY REGISTRAR <b>OCT 15 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 28511	
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) Alexander Davis				2b. DATE OF DEATH MONTH DAY YEAR 10/21/87				2c. HOUR 12:35 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11/08/1917		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SC		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven Veterans Administration Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed			12b. KIND OF BUSINESS OR INDUSTRY DAV		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 912 N. Durham St., Baltimore MD 21205			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Davis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Wylie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 250-16-5791		17. INFORMANT ADDRESS Wallace Davis 5201 E. Barry Street Apt. D							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Lung Carcinoma. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10/20/1987 to 10/21/1987, that (I) (we) last saw the deceased alive on 10/20/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Maria M. Garcia MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/21/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maria M. Garcia MD.				22e. ADDRESS Loch Raven VA Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/26/87		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST		23d. LOCATION CITY OR TOWN OWINGS MILLS,		COUNTY MD		STATE	
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC.						ADDRESS 1101 E. NORTH AVENUE		25a. DATE REC'D. BY REGISTRAR OCT 23 1987		25b. REGISTRAR'S SIGNATURE Davidson-Randall	

BP

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OCT 23 1987

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28572

1. DECEASED NAME (TYPE OR PRINT) <b>Hattie May Davis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 / 5 / 87</b>			2b. HOUR <b>6:15 P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 / 10 / 27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b>		6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2738 W. Fairmount Ave 21223</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward McNight</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Charlotte McNight</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Warren Davis 2738 W. Fairmount Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal lung cancer</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: flex; justify-content: space-between;"> <div>           DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____         </div> <div>           DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____         </div> </div>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <b>10/5/87</b> to <b>10/5/87</b> , that (I) (we) last saw the deceased alive on <b>10/5/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/6/87</b>		
22d. PHYSICIAN'S NAME (LAST OR INITIAL) <b>Jose F. Fernandez, MD</b>			22e. ADDRESS <b>St Agnes Hospital 900 Catn Ave Balto, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/9/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Maryland</b>			
24. FUNERAL DIRECTOR <b>CHARLES A. RICE</b> FUNERAL SERVICE, PA. 1200 E. FAY PLACE			25. DATE REC'D. BY REGISTRAR <b>OCT 8 1987</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 1/81  
(VRA 15, 4)



NOV 1-4 1967

Item 18a 182.21

FOR 12-30-87

4 BY REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR									
Monique R. Davis								2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. HOUR					
FEMALE		BLACK		10 24 86		1 YRS.		MONTHS		DAYS		HOURS		MIN.		10-31-		1987		7:50					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH													
MD				USA								Baltimore City													
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore				1036 Brentwood Avenue								N/A				N/A									
13a. STATE																13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		21202	
MD																		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1036 BRENTWOOD AVENUE			
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME																	
FIRST MIDDLE LAST								FIRST MIDDLE LAST																	
KELSON								DAVIS								MAUREEN DAVIS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS																	
NO				N/A				MAUREEN DAVIS 1036 BRENTWOOD AVE.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1 DEATH WAS CAUSED BY:																									
IMMEDIATE CAUSE (a) Blunt abdominal trauma																									
DUE TO, OR AS A CONSEQUENCE OF																									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																									
(b)																									
DUE TO, OR AS A CONSEQUENCE OF																									
(c)																									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																									
Malnutrition																									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?									
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
				HOUR A.M. MONTH DAY YEAR				Subject struck in abdomen																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION																	
				Home				1036 Brentwood Ave. Baltimore, MD.																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																									
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED													
Ann M. Dixon, M.D.				Deputy chief								11-1-87													
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								111 Penn Street, Baltimore, MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION													
BURIAL				11/4/87				CEDAR HILL CEMETERY				ANNE ARUNDEL CO. MD													
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE													
WM. C. MARCH F/H 1101 E. NORTH AVENUE								NOV 03 1987				Julia Benson-Randall													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**NOT TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, PLEASE RETURN THE CERTIFICATE TO THE COUNTY CLERK'S OFFICE. **TO FUNERAL DIRECTOR:** THIS CERTIFICATE MUST BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF CAPITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Ruby K. DAYE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10 17 87</b> 2b. HOUR <b>11:55</b> M			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 05 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ga.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nurse</b>	
13a. STATE <b>Md</b> 13b. COUNTY <b>None</b> 13c. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>740 Poplar Grove St. 21216</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Selema (Thornton)</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marjorie Brockington, 3915 Callaway</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>---</b> 16b. SOCIAL SECURITY NO. <b>215-22-5648</b>				17. INFORMANT ADDRESS <b>21215</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRATEABLE VENT. ARRHYTHMIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>---</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>---</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b>11:55</b> A.M. MONTH DAY YEAR <b>10 17 87</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/6</b> , 19 <b>87</b> , to <b>10/17</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/17</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Louis A. Salas</b> DEGREE <b>MD.</b>				22c. DATE SIGNED <b>10/17/87</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Louis Anthony Salas</b>				22e. ADDRESS <b>900 S. CATHEN AVE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/21/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md</b>	
24. FUNERAL DIRECTOR NAME <b>Law Funeral H Ome</b> ADDRESS <b>4611 Park Heights Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 20 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davis-Randall</b>	

MEDICAL CERTIFICATION

088551 OCT 31 84

10/31/84

10/31/84

10/31/84

10/31/84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit is placed upon pages 1 & 2 and would be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury or other traumatic event, the medical examiner must be notified at once.

68088 OCT-887

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Edward Joseph Dean			2a DATE OF DEATH MONTH DAY YEAR 10-05-87			2b HOUR 12 <sup>30</sup> AM			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 09 03 1921		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9 CITIZEN OF WHAT COUNTRY? United States		10 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
12 CITY OR TOWN OF DEATH Baltimore		13 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levinvale Nursing Home				14 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Program Analyst		15 KIND OF BUSINESS OR INDUSTRY U.S. Government	
16 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a STATE Maryland 16b COUNTY Baltimore 16c CITY OR TOWN Randallstown			17 INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			18 STREET ADDRESS / ZIP CODE 8510 Church Lane 21133			
19 FATHER'S NAME FIRST MIDDLE LAST John P. Dean			20 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Fitzgerald			21			
22 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II			23 SOCIAL SECURITY NO. 177-14-1593			24 INFORMANT Mrs. Frances Dean 8510 Church Lane Randallstown, MD. 21133			
25 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) WIDESPREAD METASTATIC CA DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10									
26a DATE OF OPERATION			26b CONDITION FOR WHICH OPERATION WAS PERFORMED			27a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		27b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
28a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			28b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			28c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
29a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			29b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			29c LOCATION STREET CITY OR TOWN COUNTY STATE			
30 I certify that (this hospital) attended the deceased from 9/25, 19 87, to 10/5, 19 87, that (we) last saw the deceased alive on 10/5, 19 87, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.									
31 SIGNATURE ESTRELITA O. KU			32 DEGREE MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			33 DATE SIGNED 10/5/87			
34 PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELITA O. KU			35 ADDRESS KEVIN J. HEBBON GERIATRIC CENTER & Hospital						
36 BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			37 DATE 10/8/87		38 NAME OF CEMETERY OR CREMATORY Lake View Mem. Park		39 LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll MD.		
40 FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. ADDRESS 8728 Liberty Road Randallstown, MD. 21133					41 DATE RECEIVED BY REGISTRAR OCT 06 1987		42 REGISTRAR'S SIGNATURE Julia [Signature]		



068360 OCT 14 1987

Item 18a, 20, 21a, b, c, d, e, f, 22a G632 dw STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Michael		MIDDLE Deans		LAST Deans		2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 10/ 3/ 19 87		2b. HOUR 9:24 a.m.	
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 1 22 1952		6. AGE (IN YEARS) (LAST BIRTHDAY) 35 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 10/ 3/ 19 87		2d. HOUR a.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Md					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 541 N. Fulton Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY J. A. Pafrey			
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2507 W. Lanvale Street 21217			
14. FATHER'S NAME FIRST MIDDLE LAST Albert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nan Deans		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-54-7408		17. INFORMANT Cathy Carter 504 N. Fulton Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Narcotic and Alcohol intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-3 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject took drugs							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) House		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 541 N. Fulton Ave. Baltimore, MD							
22. I certify that I have charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Charles P. Kokes</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER				DATE SIGNED 10/3/87			
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/10/87		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue		ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 13 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Bender-Rudolph</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA-3, RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP 814  
DHMH - 17  
(VR A15 ME (5))



069633 OCT 26 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Gertrude A. Deaver</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 17, 1987</b>			2b. HOUR <b>7:50 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 2 1895</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>92</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Florida</b>		13b. COUNTY <b>Volusia</b>		13c. CITY OR TOWN <b>Deltona</b>		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
15. FATHER'S NAME FIRST MIDDLE LAST <b>John Franklin Bache</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Anna Texas Reilly</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT <b>Otis Bowers</b>				ADDRESS <b>Same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								(b) <b>Pulmonary Edema Myocardial Infraction</b> DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>October 1, 1987</b> to <b>October 17, 1987</b> , that (I) (we) lost saw the deceased alive on <b>October 17, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Oct. 17, 1987</b>	
22d. PHYSICIAN'S NAME <b>R. Meter MD.</b>						22e. ADDRESS <b>Maryland General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>21 Oct 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Mem Garden</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Winston-Salem N. C.</b>	
24. FUNERAL DIRECTOR NAME <b>Robert E Wilhelm Funeral Home</b>						25. DATE REC'D. BY REGISTRAR <b>OCT 23 1987</b>			
ADDRESS <b>Suitland Maryland</b>						25. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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CONFIDENTIAL

OCT 23 1983

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR									
REG. NO. 28518									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEONORA L DEFELICE					2a. DATE OF DEATH MONTH DAY YEAR 10 04 87			2b. HOUR 12:10 PM	
3. SEX Female		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR 1 28 17		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHAUNCE HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 819 Eastern Ave 21202	
14. FATHER'S NAME FIRST MIDDLE LAST William L. BRACKETT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leonora L. CONEO							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No		16b. SOCIAL SECURITY NO. 24-28-3865		17. INFORMANT ADDRESS ALBERT DEFELICE 819 Eastern Ave 21202					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ATELECTASIS @ LUNG. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) METABOLIC ENCEPHALOPATHY									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS DAYS DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
9a. DATE OF OPERATION		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from 9-13, 1987, to 10-4, 1987, that (we) last saw the deceased alive on 10-4, 1987, and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (do) (did not) view the body after death.									
22b. SIGNATURE Gerardo Gordo, MD				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FORGE C. SECORDA-LOVIO, MD				22e. ADDRESS CHURCH HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 10/8/87		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.			
24. FUNERAL DIRECTOR NAME Frank J. DeLoe				ADDRESS 322 S. High St 21202		25a. DATE REC'D. BY REGISTRAR OCT 8 1987		25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRISTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

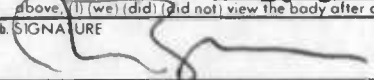
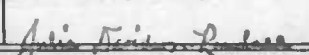
MEDICAL CERTIFICATION

100-100-100-100

100-100-100-100

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Anna m B. DeFontes</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/5/87</b>		2b. HOUR <b>6:35p<sub>M</sub></b>	
3. SEX <b>FEmale</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-24-06</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>		
12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE <b>MD.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Tomich</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Tenri Pilny</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-60-2262</b>		17. INFORMANT ADDRESS <b>LEonard P. DeFontes- 904 N. Streeper St. 21205</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Large Cell Undifferential CA Thyroid</b> DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION <b>9/18/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Thyroid Cancer</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>9-1</b> , 19 <b>87</b> , to <b>10-5</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10-5</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE 		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/6/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Jack Zimmerman</b>		22e. ADDRESS <b>Church Hospital 100 North Broadway, Balt</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-8-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy REdeemer Cem.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>						
24. FUNERAL DIRECTOR NAME ADDRESS <b>John C. Miller, Inc., -6415 Belair Road-21206</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 7 1987</b>		25b. REGISTRAR'S SIGNATURE 		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY K. DEITZ</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 26, 1987</b>		2b. HOUR <b>6:30 P.M.</b>
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>AUG. 21, 1907</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>PENNA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2715 JENNER DR. APT. D. (21209)</b>		12a. OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>ASSISTANT BUYER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. CITY OR TOWN <b>MARYLAND</b> 13c. COUNTY <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ISAAC JONAH DEITZ</b>			15. MOTHER'S MAIDEN NAME MIDDLE LAST <b>JENNIE KOHN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO <b>212-09-9424</b>	17. INFORMANT <b>ELIZABETH DEITZ</b> <b>2715 JENNER DR., APT. D BALTO., MMD 21209</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>multiple myeloma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>10/23</b> , 19 <b>87</b> , to <b>Oct 26</b> , 19 <b>87</b> , that (I) (we) saw the deceased alive on <b>10/23</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Sheldon C. Kravitz, M.D.</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/27/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHELDON C. KRAVITZ</b>		22e. ADDRESS <b>201 E. University Pkway 21218</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>10/28/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BNAI ISRAEL CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO., MD.</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS.</b> <b>6010 REISTERSTOWN RD. BALTO., MD. (21215)</b>			25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1987</b> 25b. REGISTRAR'S SIGNATURE <i>Julia Benishon-Randall</i>		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholders. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, the medical examiner will be notified in writing.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bertha B. Delfosse					2a. DATE OF DEATH MONTH DAY YEAR October 15, 1987			2b. HOUR 7 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 10, 1925		6. AGE (IN YEARS (LAST BIRTHDAY)) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 930 Thompson Blvd. 21221	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Betz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Not Known						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-24-9272		17. INFORMANT ADDRESS Earl Delfosse 1489 Harford Square Dr. 21040					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Stage IV Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Multiple Decubitus - Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the undelying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Malnutrition &amp; Dehydration - PCVA - Alzheimer Ds - PCADon</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-4</u> 19 <u>82</u> to <u>10-15</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>10-15</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Lindsay Bennett</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>L. Bennett</u>					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-19-87		23c. NAME OF CEMETERY OR CREMATORY Holly Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk		ADDRESS 7922 Wise Ave. Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR OCT 19 1987		25b. REGISTRAR'S SIGNATURE <u>Lindsay Bennett</u>			



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper pages. Page 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REG. NO.

FOR  
STATE  
REGISTRAR

Katherine C. Dennstedt CERTIFICATE OF DEATH

1. BASED NAME (TYPE OR PRINT) <u>Katherine C. Dennstedt</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>10 30 87</u>		2b. HOUR <u>3 P M</u>
3. SEX <u>FEMALE</u>	4. RACE <u>WHITE</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>6 05 03</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Baltimore General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Home Maker</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13a. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>Baltimore</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>3715 Annapolis Rd 21227</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>George Cord</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Annie Eleanor</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>No</u>		16b. SOCIAL SECURITY NO. <u>220-071-8625</u>		17. INFORMANT ADDRESS <u>Maryland 21227</u> <u>Ralph Dennstedt 2804 Oak Grove Ave, Balto</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> 19 <u>87</u> to <u>10/30</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>10/30</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. Nicholas J. Manole</u>		DEGREE <u></u>		22c. DATE SIGNED <u>10/30/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Nicholas J. Manole</u>		22e. ADDRESS <u>South Baltimore General Hosp, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>11/2/87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Howard MD</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>George J. Gonca 4001 Ritchie Hwy Balto Md</u>			25a. DATE REC'D BY REGISTRAR <u>NOV 3 1987</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit removes carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RANDOLPH JOSEPH DENT			2a. DATE OF DEATH MONTH DAY YEAR 10 14 87			2b. HOUR M AM			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 3 1 19		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
12. CITY OR TOWN OF DEATH BALTIMORE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6200 ODELL AVE. APT. 1502				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		15. KIND OF BUSINESS OR INDUSTRY N/A	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6200 ODELL AVE APT. 1502	
14. FATHER'S NAME FIRST MIDDLE LAST RANDOLPH DENT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES SOMMERSVILLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-01-9089		17. INFORMANT ADDRESS RITA HARDY 2029 SINCLAIR LANE 21213					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes with autonomic neuropathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD, 1/4 Tracheostomy for ca. Larynx.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Mukesh Lubar</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mukesh Lubar				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/19/87		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM PK CEM		23d. LOCATION CITY OR TOWN COUNTY STATE ARBUTUS MD			
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC.				ADDRESS 1101 E. NORTH AVENUE		25a. DATE REC'D. BY REGISTRAR OCT 16 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Rudolph	

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANK L. DEPPISH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCT 18 1987</b>		2b. HOUR <b>4<sup>15</sup> A M</b>		
3. SEX <b>male</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 26 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANCIS SCOTT Key Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>MARYLAND Baltimore Dundalk</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank M. Deppish</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Magdalena Hasenie</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215-05-5220</b>		17. INFORMANT ADDRESS <b>Russell Deppish 3520 Dunhaven Road 21222</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**ANOXIC ENCEPHALOPATHY**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last(b) **CARDIAC ARREST**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Arteriosclerotic cardiovascular disease**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>October 3, 1987</b> to <b>October 18, 1987</b> , that (I) (we) last saw the deceased alive on <b>October 18, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R. W. Freeman MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Oct 18, 1987</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD W FREEMAN MD</b>				22e. ADDRESS <b>4440 EASTVIEW AVE., Baltimore, MD 21224</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/21/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Connelly Funeral Home of Dundalk 21222</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>OCT 21 1987</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These pages remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 1 is for burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 above only injury, or other traumatic event, the medical examiner must be notified of cause.)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 signed any injury, or other traumatic event, the medical examiner must be notified to investigate.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 28585	
1. DECEASED NAME (TYPE OR PRINT) <b>EMIL DEREY</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>12</b> YEAR <b>87</b>		2b. HOUR <b>6:00 AM</b>	
3 SEX <b>Male</b>	4 RACE <b>Ukrainian</b>	5. DATE OF BIRTH MONTH <b>04</b> DAY <b>15</b> YEAR <b>11</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>26</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>UKRAINE</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.		
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>BALTIMORE</b>			13b. COUNTY <b>DAKOTA</b>	13c. CITY OR TOWN <b>DAKOTA</b>	13d. STREET ADDRESS / ZIP CODE <b>2003 FERNGLIN WAY 21228</b>	
14. FATHER'S NAME FIRST <b>JOSEPH</b> MIDDLE <b>DERIJ</b> LAST <b>DERIJ</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARIA</b> MIDDLE <b>TATARYN</b> LAST <b>TATARYN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unknown</b>		16b. SOCIAL SECURITY NO. <b>213-30-3772</b>		17 INFORMANT <b>RASAM ATIKH</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Intracranial hemorrhage</b>						
19a. DATE OF OPERATION <b>8/13/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intracranial Hemorrhage</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/12/87</b> to <b>9/12/87</b> , that (I) (we) lost <b>87</b> saw the deceased alive on <b>9/12</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/12/87</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RASAM ATIKH</b>
22e. ADDRESS <b>1203 K COLBURN RD. BALTO. 21239</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/16/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL UKR. CEM</b>		23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE
24 FUNERAL DIRECTOR NAME <b>LILLY + ZEFILER, INC.</b> ADDRESS <b>1901 EASTERN AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 8 5 0 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Harold R. Deshong</b>			2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 5 1987</b>			2b. HOUR <b>5:34</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9/22/33</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>54</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10 5 1987</b>	7d. HOUR <b>5:34</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
11. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hopsital (STU)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
13a. STATE <b>Pa.</b>			13b. COUNTY <b>Franklin</b>	13c. CITY OR TOWN <b>Ft. Loudon</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>13061 Main St. 99999</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>E. Ray Deshong</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Carbaugh</b>			16. SOCIAL SECURITY NO. <b>211-26-7135</b>			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			17b. SOCIAL SECURITY NO. <b>211-26-7135</b>			17c. INFORMANT <b>Janet Deshong</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Head injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>1:06xx 10 5 1987</b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1:06xx 10 5 1987</b>						
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver of tractor-trailer that overturned</b>			21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 81 ramp to I-70, Hagerstown, Washington, MD.</b>						
22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <b>Mario F. Golle, Jr.</b>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>10/5/87</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Mario F. Golle, Jr., M.D.</b>			ADDRESS <b>111 Penn St. Balto. MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/9/87</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Upton Brethren Cem.</b>			
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Peters Twp., Franklin Co. Pa.</b>			24. FUNERAL DIRECTOR NAME ADDRESS <b>M. W. Lininger</b>			25. DATE REC'D. BY REGISTRAR <b>OCT 13 1987</b>			
25b. REGISTRAR'S SIGNATURE <b>Julia Deshong</b>									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PERSON IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

28387  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAULINE R. DEUKMAN			2a. DATE OF DEATH MONTH DAY YEAR 10/3/87			2b. HOUR 11:15 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01 01 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY, BALTO. MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6316 GREENSPRING 21209	
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC DRUKMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CECELIA BIEGER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-52-2099		17. INFORMANT MRS. SYLVIA ACKER APT. 208 6316 GREENSPRING AVE. BALTO., MD 21209					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) attended the deceased from 10/27/87, 19 87, to 10/3/87, 19 87, that (I) (we) last saw the deceased alive on 10/31/87, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.									
22b. SIGNATURE F. Rosenthal				DEGREE MD.				22c. DATE SIGNED 10/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS ROSENTHAL				22e. ADDRESS SINAI HOSPITAL BALTIMORE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 6, 1987		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR OCT 08 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Twin plates to remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to removal, for removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, death, traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

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070406 NOV 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMM - 16 60M 7/84  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert L. DEWITT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Oct. 27, 87</b>		2b. HOUR <b>8:35 P</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 27 37</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city MD.</b>		
10. CITY OR TOWN OF DEATH <b>Randalltown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Walsh</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>McArdle</b>		13a. STREET ADDRESS / ZIP CODE <b>3300 Ludgate Road 21215</b>		13b. CITY OR TOWN <b>Baltimore</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Luther Smith</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ola DeWitt</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>241-48-1912</b>		17. INFORMANT <b>Joyce DeWitt</b>		ADDRESS <b>3300 Ludgate Rd</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Metastatic carcinoma of**

DUE TO, OR AS A CONSEQUENCE OF

(b) **the lung**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 28, 1987</b> to <b>Oct. 27, 1987</b> , that (I) (we) lost saw the deceased alive on <b>Oct. 27, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sharon C. Parnell, M.D.</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-27-87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GHASSEM PAURMOTABBEI</b>		22e. ADDRESS <b>Balt. Co. General Hospital</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/31/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H West</b>				ADDRESS <b>4300 Wabash Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1987</b>	
				REGISTRAR'S SIGNATURE <b>Julia Darden-Rodgers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





070258 OCT 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE FILED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR		FOR		STATE OF MARYLAND		2 8 3 0 9	
DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		REG. NO.	
Charles		E.	Dial				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS	7a. DATE KNOWN OF DEATH	7b. HOUR
male	negro	1-24-42	45 YRS.			10 25 19 87	10 25 19 87
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore, Md	U. S. A.			Baltimore City		Adminstr Baltimore City School	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore	820 Belgium Avenue	Adminstr Baltimore City School					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS			
Maryland		BALTO.		820 Belgium Ave.		21218	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT ADDRESS	
Joseph C.	Lillian T. Thomas	yes		219-40-3096		Mrs. Michelle Dial 820 Belgium Ave 21218	
CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1 DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED	
Dennis F. Smyth, M.D.		Assistant				10/25/87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		CITY OR TOWN		STATE	
Dennis F. Smyth, M.D.		111 Penn St.		Balto.		MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
BURIAL	10-30-87	Garrison Forest		Balto.		Co. Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Joseph L. Russ		2222 W. North Ave.		OCT 27 1987		John Gordon Readles	



NOTE: Name 1-21-81  
to California, in 2-81

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR					
ROBERT M. DIBARTOLOMEO SR.			OCTOBER 30, 1987									4:07A M								
3. SEX M			4. RACE W I			5. DATE OF BIRTH MONTH DAY YEAR 6-20-1937			6. AGE (IN YEARS (LAST BIRTHDAY)) 50 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.											
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor			12b. KIND OF BUSINESS OR INDUSTRY Building											
13a. STATE Md.			13b. COUNTY Baltimore			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS / ZIP CODE 3012 E. Fayette St. 21224											
14. FATHER'S NAME FIRST MIDDLE LAST Louis - DiBartolomeo			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith - Brown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -			16b. SOCIAL SECURITY NO. 216-32-7261			17. INFORMANT Bonnie S. DiBartolomeo			ADDRESS 3012 E. Fayette St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) DILATED CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 2 years																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from 8/86, 19, to 10/29, 19, 87, that (I) (we) last saw the deceased alive on 10/29, 19, 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE Arthur M. Feldman MD															DEGREE MD			22c. DATE SIGNED 10/30/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR M. FELDMAN															22e. ADDRESS HALSTEAD 500 JOHNS HOPKINS HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-2-87			23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.											
24. FUNERAL DIRECTOR Name Address Kathy Heller - 7527 Harford Rd.															25a. DATE REC'D. BY REGISTRAR NOV 03 1987			25b. REGISTRAR'S SIGNATURE Julia Tindon-Randall		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED NON MED DR A. DIXON PER MR. RICHARDSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1- DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

JAMES

L.

DICKIE

2a. DATE KNOWN OF DEATH  
ESTIMATED ☒ MONTH DAY YEAR  
DEATH MATED ☐ 10 27 19 87

2b. HOUR  
M 6:04  
A M

3. SEX  
Male

4 RACE  
Cauca.

5. DATE OF BIRTH  
MONTH DAY YEAR  
Apr. 3, 1898

6. AGE (IN YEARS)  
LAST BIRTHDAY  
89 YRS.

IF UNDER 1 YR.  
MONTHS DAYS HOURS MIN

IF UNDER 24 HRS.  
MONTHS DAYS HOURS MIN

7c. DATE PRONOUNCED DEAD  
MONTH DAY YEAR  
10 27 19 87

8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Scotland

7b. CITIZEN OF WHAT COUNTRY?  
U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
Baltimore City MD.

10. CITY OR TOWN OF DEATH  
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
University Hospital (STU)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Bridge Constr.

12b. KIND OF BUSINESS OR INDUSTRY  
Construct.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland

13b. COUNTY  
Caroline

13c. CITY OR TOWN  
Denton

13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐

13e. STREET ADDRESS  
700 Market St. 21629

14. FATHER'S NAME  
FIRST MIDDLE LAST  
John Dickie

15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST  
Elizabeth Jane Lamont

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)  
No

16b. SOCIAL SECURITY NO.  
152102255

17. INFORMANT ADDRESS  
Elizabeth Brown, Dover, Delaware

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chest injuries with complications

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR MONTH DAY YEAR  
1:35 P.M. 10-5- 19 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Driver of auto/truck collision,

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
road

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE  
Rt. 328 & Rt. 404, Denton, Caroline MD

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐.

Inspection ☒.

Inquiry ☐.

and in my opinion

death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

M.D.

TITLE (SPECIFY)  
Assistant

MEDICAL EXAMINER

DATE SIGNED

10-27-87

EXAMINER'S NAME  
(TYPE OR PRINT)

Charles P. Kokes, M.D.

ADDRESS

111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

10/30/87

23c. NAME OF CEMETERY OR CREMATORY

Denton Cemetery

23d. LOCATION  
CITY OR TOWN

Denton Caroline MD

COUNTY

STATE

24. FUNERAL DIRECTOR  
NAME

Moore Funeral Home, 12 S2nd St. Denton

ADDRESS

25a. DATE REC'D. BY REGISTRAR

NOV 03 1987

25b. REGISTRAR'S SIGNATURE

*Julia Anderson-Parker*

DIVISION OF VITAL RECORDS, 201 W. BRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF THE SIGNATURE OF THE MEDICAL EXAMINER. THE MEDICAL EXAMINER'S SIGNATURE AND TITLE SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. BRESTON ST., BALTIMORE, MD. 21201. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. BRESTON ST., BALTIMORE, MD. 21201. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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068-121 OCT-87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES</b> <b>Dennis</b> <b>Dickson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October</b> <b>6</b> <b>1987</b>		2b. HOUR <b>920A</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>February</b> <b>8</b> <b>1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GEN. HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR EMPLOYMENT) <b>TAXI DRIVER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Cab Co.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13a. COUNTY <b>Anne Arundel</b> 13a. CITY OR TOWN <b>Glen Burnie</b>			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13c. STREET ADDRESS / ZIP CODE <b>Apt K</b> <b>102 Governor's Court 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert</b> <b>Dickson, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY</b> <b>Zosiak</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT (Son) ADDRESS <b>Dennis J. Dickson 1711 Richardson Road Westminister, Md 21157</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Respiratory Failure**

DUE TO, OR AS A CONSEQUENCE OF

(b)

**2° Metastatic cholangiocarcinoma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

**Cran Negative Sepsis**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Chronic obstructive pulmonary disease**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>10/2</b> 19 <b>87</b> , to <b>10/6</b> 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>10/7/87</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Michael Kazakus</b>		DEGREE		22c. DATE SIGNED <b>10/6/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL KAZAK</b>		22e. ADDRESS <b>3001 South Hanover St. BALT. MD 21223</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Oct 8 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home, Glen Burnie, Md. 21061</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 8 1987</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Anthony J. Dietz, Jr.					October 7, 1987					5:30 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	White	September 11, 1925		62 YRS.		0 27				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	USA			Baltimore City						MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore	Francis Scott Key Medical Center		Bethlehem Steel							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland		Baltimore		Edgemere		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2813 Willow Ave. 21219		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
Anthony J. Dietz, Sr.		Celeste Palmer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Yes		WW II 219-18-2947		Mary R. Dietz		2813 Willow Ave. 21219				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension + Cardiac failure</u>			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>September 24</u> 19 <u>87</u> , to <u>October 7</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>October 7</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>Adelaide S. Robb</u>		DEGREE		22c. DATE SIGNED			
				10/17/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Adelaide S Robb MD		FSK Hospital Eastern Ave Balt					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)	
Burial		10-10-87		Garrison Forest		Owings Mills Maryland	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Duda-Ruck Funeral Home of Dundalk		7922 Wise Ave. Dundalk, MD 21222		OCT 09 1987		<u>Adelaide S. Robb</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



08327 726 4147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1- DECEASED NAME (TYPE OR PRINT) <b>Beatrice Diggs</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10 11 87</b>		2b. HOUR <b>6:13 PM</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 1 25</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Baltimore</b>	13c. STREET ADDRESS / ZIP CODE <b>1007 N. Bentalou St. 21216</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Will Rich</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Rich</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>216-14-9636</b>		17. INFORMANT ADDRESS <b>Arva Jones 1007 N. Bentalou St. 21216</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/15</b> 19 <b>87</b> to <b>10/11</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/11</b> 19 <b>87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Rupert Williams</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10/12/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rupert Williams</b>		22e. ADDRESS <b>4200 EDMONSON AVE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/16/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Star</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Md.</b>		25a. DATE REC'D BY REGISTRAR <b>Oct 20 1987</b>			
24. FUNERAL DIRECTOR <b>Estep Fun. Home 1300 Eutaw Pl.</b>		25b. REGISTRAR'S SIGNATURE <b>John Jones</b>			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 8 5 9 3

REG. NO.

1- STATE REGISTRAR		2a DATE KNOWN OF DEATH		2b HOUR	
DECEASED NAME (TYPE OR PRINT)		DATE ESTIMATED		MONTH DAY YEAR	
INEZ		10-28-87		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	7a DATE PRONOUNCED DEAD	7b HOUR
FEMALE	BLACK	7 25 28	59 YRS.	10-28-87	5:45P
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED	8 NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
MD	U.S.A.	WIDOWED	DIVORCED	Baltimore City	
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Baltimore	426 Winston Avenue #6	SOC SEC		STATE	
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS	
MD		BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	426 WINSTON AVENUE 21212	
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME	16a WAS DECEASED EVER IN U.S. ARMED FORCES?			
HERM	MABLE	NO			
16b SOCIAL SECURITY NO.	17 INFORMANT	17 ADDRESS			
213-26-7837	HORACE DISMOND SR.	426 WINSTON AVENUE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) _____					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f LOCATION		
			STREET CITY OR TOWN COUNTY STATE		
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)			DATE SIGNED
<i>Dennis F. Smyth</i>		Assistant			10-29-87
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Dennis F. Smyth, M.D.		111 Penn Street			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION		
BURIAL	11/2/87	PLEASANT REST CEMETERY	TOWSON		
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
NAME		OCT 30 1987		<i>Julia Barbara Rucker</i>	
WM. C. MARCH F/H, INC.		1101 E. NORTH AVENUE			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 28596  
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18, item 21 is marked on item 18, item 21 is marked on item 18.

1 DECEASED NAME (TYPE OR PRINT) <b>B LOUIS JUNIOR DIVERS</b>			2a DATE OF DEATH MONTH DAY YEAR <b>10 12 87</b>			2b HOUR <b>135 PM</b>						
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>JANUARY 7, 1930</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS			7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		9b CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
11 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		12 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FSK MC</b>				13a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACETELYNE BURNER</b>			13b KIND OF BUSINESS OR INDUSTRY <b>SHIP BUILDING</b>			
14a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a STATE <b>MARYLAND</b> 14b COUNTY <b>BALTIMORE</b> 14c CITY OR TOWN <b>DUNDALK</b>						14d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14e STREET ADDRESS / ZIP CODE <b>2109 CAMERON COURT / 21222</b>			
15a FATHER'S NAME FIRST MIDDLE LAST <b>CLARENCE DIVERS</b>			15b MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY MITCHELL</b>			16 ADDRESS <b>GLEN BURNIE, MD. 21061</b>						
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		18 SOCIAL SECURITY NO <b>227-34-4487</b>		19 INFORMANT <b>CLARENCE R. DIVERS</b>						20 ADDRESS <b>8213 KRAMER COURT</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC LUNG CA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <b>10-9</b> , 19 <b>87</b> , to <b>10-12</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10-12</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <b>[Signature]</b>						DEGREE <b>MD</b>			22c DATE SIGNED <b>10-12-87</b> <b>NO PM A</b>			
22d PHYSICIAN'S NAME <b>LEFT</b>						22e ADDRESS <b>FSK MC</b>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b DATE <b>OCTOBER 14, 1987</b>		23c NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CREMATORY</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>				
24 FUNERAL DIRECTOR NAME <b>WALTER BROOKS BRADLEY, INC.</b>						ADDRESS <b>21222 DUNDALK, MD.</b>		25a DATE REC'D. BY REGISTRAR <b>OCT 13 1987</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>		





FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>JIMMY LEE DIXON</b>			2a DATE OF DEATH MONTH <b>10</b> DAY <b>19</b> YEAR <b>87</b>			2b HOUR <b>M</b>					
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH <b>1</b> DAY <b>7</b> YEAR <b>50</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>37</b> YRS		7 IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8 IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NC</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>130 N. AISQUITH STREET 1J</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNEMPLOYED</b>		12b KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
13a STATE <b>MD</b>		13b COUNTY <b>BALTIMORE</b>		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>130 N. AISQUITH ST. APT 1J</b>		21202	
14 FATHER'S NAME FIRST <b>WARREN</b> MIDDLE <b></b> LAST <b>HADART</b>				15 MOTHER'S MAIDEN NAME FIRST <b>DOROTHY</b> MIDDLE <b></b> LAST <b>DIXON</b>				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b SOCIAL SECURITY NO. <b>243-80-0672</b>				17 INFORMANT <b>FANNIE DIXON</b>				ADDRESS <b>HOOKERTON, NC</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARRHYTHMIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&lt; 10 MINUTES</b> <b>5 YRS</b> <b>10 YRS.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>END STAGE RENAL FAILURE</b>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/11</b> , 19 <b>87</b> , to <b>10/19</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/14</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Paul C. Szymon</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. SAPIR</b>				22e. ADDRESS <b>9 E. CHASE ST. BALT 21202</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>10/25/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHURCH CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FARMSVILLE NC</b>		23e. DATE RECEIVED BY REGISTRAR (SEE INSTRUCTIONS)	
24. FUNERAL DIRECTOR NAME <b>WM. C. MARCH F/H</b>				ADDRESS <b>1101 E. NORTH AVENUE</b>				25. DATE RECEIVED BY REGISTRAR (SEE INSTRUCTIONS) <b>10/23/87</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please relieve carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR2a. DECEASED NAME  
(TYPE OR PRINT)

Edith

FIRST

MIDDLE

LAST

R.

Doerr

2b. DATE OF DEATH

10-28-87

MONTH

DAY

YEAR

2c. HOUR

4:35P

3. SEX

Fe

4. RACE

white

5. DATE OF BIRTH

MONTH

DAY

YEAR

4

09

18

6. AGE (IN YEARS (LAST BIRTHDAY))

69

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Balto, Md.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Balt City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

MFLNH (Chronic Care)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

13c. CITY OR TOWN

Balto

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS, ZIP CODE

428 N. Kenwood

21224

14. FATHER'S NAME

Joseph

MIDDLE

LAST

Russo

15. MOTHER'S MAIDEN NAME

Helena

MIDDLE

LAST

Mazzagatti

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

218-05-6849

17. INFORMANT

Brenda Greenfield 26 S. Curley St

ADDRESS

21224

18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) COPD &amp; possible TB

DUE TO, OR AS A CONSEQUENCE OF

(c) Malnutrition / Anemia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

hx of CHF, Meniere's Ds

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 7-17, 19 87, to 10-28, 19 87, that (I) (we) last saw the deceased alive on 10-28, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

10-28-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

10/31/87

23c. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

23d. LOCATION

Balto

COUNTY

STATE

24. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto St.

25a. DATE RECEIVED BY REGISTRAR

OCT 30 1987

25b. REGISTRAR'S SIGNATURE

John A. Moran

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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Reference

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Small note

Reference

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10-98-21

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alexander N. Dogan			2a. DATE OF DEATH MONTH DAY YEAR 10/29/87		2b. HOUR 0200 AM	
3 SEX MALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 16 1911		
6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAITRE D		12b. GROUP BUSINESS OR INDUSTRY ADMIN SERVICES		
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		17a. STREET ADDRESS / ZIP CODE BALTO. MD. 3300 LEIGHTON AVE. 21215		
13a. STATE MARYLAND		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST WALTER T. DOGAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EFFIE TURNER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		
16b. SOCIAL SECURITY NO. WW II		17. INFORMANT MRS. ADDRESS BALTIMORE, MD. 21215		17b. FLORENCE DOGAN 3300 LEIGHTON AVE.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CIRRHOTIC ENCEPHALOPATHY DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/28, 1987, to 10/29, 1987, that (I) (we) last saw the deceased alive on 10/28, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Ann S. Tran, MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/29/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ann S. Tran M.D.		22e. ADDRESS Union Memorial Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/3/1987		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM.		
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND		24. FUNERAL DIRECTOR WALTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY, BALTO, MD. 21216		25a. DATE REC'D. BY REGISTRAR NOV 6 1987		
25b. REGISTRAR'S SIGNATURE Brendon R. Rader						

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

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20% COTTON

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NOV 8 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is checked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P M	
ELIZABETH DONALDSON				OCTOBER 11, 1987		12:16 M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
FEMALE	BLACK	3 9 00		87 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
SC	U.S.A.			BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	THE JOHNS HOPKINS HOSPITAL			RETIRED		N/A	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MD			BALTO.			728 EAST 20th STREET 21218	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. ADDRESS			
JOHN CUNNINGHAM		LIZZIE CUNNINGHAM					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
NO		213-48-8521		ELIZABETH M. CHEATHAM 728 E. 20th STREET			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIAC Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPTIC SHOCK</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>5 min</u> <u>12 hours</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/11</u> , 19 <u>87</u> , to <u>10/11</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>10/11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		27b. SIGNATURE <u>S.A. Strickberger</u> DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		27c. DATE SIGNED <u>10/11/87</u>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. A. STRICKBERGER</u>		27e. ADDRESS <u>600 N. WOLFE ST. BALTO., MD. 21205</u> <u>JOHNS HOPKINS Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>10/16/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT ZION CEMETERY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>LANSOWNE, MD</u>	
24. FUNERAL DIRECTOR NAME <u>WM. C. MARCH F/H, INC.</u> ADDRESS <u>1101 E. NORTH AVENUE</u>				25a. DATE REC'D. BY REGISTRAR <u>OCT 16 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>	

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows the injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28001

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Esther DOPKIN		2a. DATE OF DEATH MONTH DAY YEAR 10/10/87		2b. HOUR 440A <sup>AM</sup>	
3. SEX F FEMALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 12 27 04	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE MARYLAND COUNTY XXXX	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Simon Hospital		12a. USUAL OCCUPATION (TYPE, WORK, OR CLASS OF WORKING LIFE) HOUSEWIFE N/A	12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD 13c. COUNTY Balt.		13d. CITY OR TOWN Balt.	13e. STREET ADDRESS, ZIP CODE 6604 AMLEIGH RD. 21209		
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC XXXX ABEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE XXXX KATZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. XXXXXX		17. INFORMANT MICHAEL H. DOPKIN 6604 AMLEIGH RD. Simon Hospital Baltimore #21209	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPOCEPHALUS - STROKE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD/CHF - Diabetes</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes YES YES
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
22a. I certify that (I) (this hospital) attended the deceased from 3/23/87, 19 to 10/10, 19 87, that (I) saw the deceased alive on 10/10/87, 19, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death.					
22b. SIGNATURE Kenneth M Zonies MD		22c. ADDRESS 1777 REISTERSTOWN RD BALTO. MD		22d. DATE SIGNED 10/10/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-11-87		23c. NAME OF CEMETERY OR CREMATORY SHAAREI ZION CONG	
23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD		24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215			
25a. DATE REC'D. BY REGISTRAR OCT 15 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "X" and "1" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbonpapers, Page 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 28602	
1- FOR STATE REGISTRAR		DECEASED NAME (PRINT) FIRST MIDDLE LAST LAURA J. DORN				2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 18 1987		7b. HOUR 9 <sup>25</sup> AM			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR October 20 1906		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH CITY, GIVE STREET ADDRESS) NORTH CHARLES GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY Balto		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2407 Louise Ave #101 21214			
14. FATHER'S NAME FIRST MIDDLE LAST William Gray				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Orpha Fix Bowen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577-07-7510		17. INFORMANT Gus Baker		ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO - RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRO-VASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10-2-</u> 19 <u>87</u> , to <u>10-18</u> 19 <u>87</u> , that (we) last saw the deceased alive on <u>10-18-</u> 19 <u>87</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Thomas S. Miller</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/18/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS S. MILLER				22e. ADDRESS NORTH CHARLES HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 22 Oct 1987		23c. NAME OF CEMETERY OR CREMATORY Washington National Suitland		23d. LOCATION CITY OR TOWN COUNTY STATE PG MD			
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home				ADDRESS Suitland, Md.				25a. DATE REC'D BY REGISTRAR OCT 23 1987			

MEDICAL CERTIFICATION

069892 OCT 28 81

OCT 23 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corresponding pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT) <b>Elias Albert Dorsey</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Wed. 10 21 87</b>		2b. HOUR <b>00:49 AM</b>	
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 6 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PAINTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONTRACTOR</b>
13a. STATE <b>Md</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>AUGUSTUS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FLORENCE FISHER</b>		13e. STREET ADDRESS / ZIP CODE <b>5311 Denmore Ave 21215</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220 05 9819</b>		17. INFORMANT ADDRESS <b>MRS. CARRIE M. DORSEY 5311 DENMORE AVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> Approximate interval between onset and death <b>Unknown</b> <b>Many years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>S. Hahn</b>		DEGREE <b>S. Hahn</b>		22c. DATE SIGNED <b>10/21</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. Hahn</b>		22e. ADDRESS <b>Sinai Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/24/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CREST LAWN CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>MARRIOTTSTVILLE (HOWARD) MD.</b>					
24. FUNERAL DIRECTOR NAME <b>LEWIS T. GWYNN</b>		ADDRESS <b>4517 PARK HEIGHTS AVE. 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 23 1987</b>	
				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MINNIE (NMN) DOYCHICH</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>OCT. 4, 1987</b>		2b. HOUR <b>4:45p M</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 9 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hungary</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Manufacturing</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Relay</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>4807 Ruby Avenue 21227</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown Garchevo</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-01-2697</b>		17. INFORMANT ADDRESS <b>Helen Doychich 4807 Ruby Ave. 21227</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Right Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from <b>SEP. 30</b> , 19 <b>87</b> , to <b>OCT. 4</b> , 19 <b>87</b> , that (X) (we) last saw the deceased alive on <b>OCT. 4</b> , 19 <b>87</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.					
22b. SIGNATURE <b>Dr. Wong</b>		DEGREE		22c. DATE SIGNED <b>OCT 4 1987</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Wong</b>		22e. ADDRESS <b>900 S. CATON AVE. BALTO. MD, 21229</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/8/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>			
25a. DATE REC'D. BY REGISTRAR <b>OCT 06 1987</b>		25b. REGISTRAR'S SIGNATURE			

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069113 OCT 20 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LARRY D DREHER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 11 87</b>			2b. HOUR <b>3:45 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 31 39</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS		7. IF UNDER 1 YEAR IF UNDER 22 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Beaver Falls, PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALT</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALT, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIV. MD HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ADMINISTRATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SERVICE</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALT</b>		13c. CITY OR TOWN <b>BALT</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>36 S. PACA ST. 21201</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DAS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NANCY HILL</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>211-30-6347</b>			17. INFORMANT <b>MRS. JOANN JOHNS DREHER</b>			ADDRESS <b>BALTIMORE, MD 36 S. PACA ST.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>brain death</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>massive intraventricular hemorrhage</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1</b> , 19 <b>86</b> , to <b>present</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>10/11</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Brad A. Sommer</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/11/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRAD TROMMER</b>			22e. ADDRESS <b>22 S. Greene St, BALT, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10/14/1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARRISON FOREST VET. CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>WINTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY. BALTO, MD. 21216</b>					25a. DATE REC'D <b>OCT 19 1987</b>		25b. SEARCHED INDEXED <b>P</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified.

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NOTION FIBER, INC.  
1000 FIBER ROAD  
BIRMINGHAM, AL 35202

068656 OCT 15 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 28000

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
John F. Dressel Sr.				10-12-87		6:10pm	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male	Caucasion	11-6-1921		65 yrs.			
7a. BIRTHPLACE (STATE OR FOREIGN CITY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD.	USA			Baltimore City MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	4111 Coleman Avenue		Boiler Maker		Shipbuilding & Drydock		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE		
Md.			Balto.		21213 4111 Coleman Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE BRANCH AND DATES)			
Joseph Dressel		Amelia Leveck		yes <input checked="" type="checkbox"/> WWII			
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
220-01-5239A		Walena Dressel same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>LUNG CARCINOMA</u>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>November 85</u> to <u>10/12/87</u> , that (I) (we) last saw the deceased alive on <u>9/23/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Dr. Peter Stamas						10/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Dr. Peter Stamas		101 W REAR ST Balt 21201					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		10-15-87		Holy Redeemer Cem.		Balto., Md. COUNTY STATE	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213				OCT 14 1987		Julia Anderson-Randall	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this condition.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JOHN A. DRIGGERS				2a. DATE OF DEATH MONTH DAY YEAR 10 8 87		2b. HOUR 1700 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 14, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Truck Repair	
13a. STATE Maryland				13b. COUNTY -		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Driggins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Atlanta -			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW II 250 28 5987		17. INFORMANT ADDRESS Irene A. Driggers 3613 Buena Vista Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis 20 aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10' 48'	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pulmonary interstitial fibrosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/7</u> , 19 <u>87</u> , to <u>10/8</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/8</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10/8/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ph: H. p. O. Hale</u>				22e. ADDRESS UNION MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (USE P. 1) Burial		23b. DATE 10-12-87		23c. NAME OF CEMETERY OR CREMATORY Crest Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Carroll Co., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Burgee-Henss Funeral Home, Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR OCT 14 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. The permit remains the property of the funeral director and must be returned with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mitchell M. Driver			2a. DATE OF DEATH MONTH DAY YEAR 10 9 1987			2b. HOUR M	
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 9 16 1905		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3303 Gwynns Falls Parkway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
12b. KIND OF BUSINESS OR INDUSTRY Longshoreman		13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7400 Marston Road 21207		14. FATHER'S NAME FIRST MIDDLE LAST Joshua Driver		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Lemon	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Rae E. Holden 1329 Robin Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic cancer</u> DUE TO, OR AS A CONSEQUENCE OF <u>rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-21-87</u> 19 <u>87</u> to <u>Jan 87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8-21-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		22c. DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>10-12-87</u>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOSEPH A. PETER MD</u>		22f. ADDRESS <u>17 CHARLES PARK RD</u> <u>ROITERS STATION</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/13/87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West				ADDRESS 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR OCT 13 1987	
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
October 17, 1987 12:45pm1. DECEASED NAME FIRST MIDDLE LAST  
Margaret Gordon Droter3. SEX  
Female4. RACE  
White5. DATE OF BIRTH MONTH DAY YEAR  
8 27 236. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.  
64 YRS MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Pennsylvania7b. CITIZEN OF WHAT COUNTRY?  
U.S.A.8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☒9. BALTIMORE CITY OR COUNTY OF DEATH  
Baltimore City MD.10. CITY OR TOWN OF DEATH  
Baltimore11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Church Hospital12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)  
Housework12b. KIND OF BUSINESS OR INDUSTRY  
At HomeUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE 13b. COUNTY 13c. CITY OR TOWN  
Md. Baltimore13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐13e. STREET ADDRESS / ZIP CODE  
517 South Bouldin St. 2122414. FATHER'S NAME FIRST MIDDLE LAST  
Edward Wilds15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Jennie Wood16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN) No16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)  
192-18-693417. INFORMANT ADDRESS  
Michael J. Droter 517 S. Bouldin St. 2122418. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Obesity

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 1921c. HOW INJURY OCCURRED  
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.22b. SIGNATURE  
Kang Sun Lee MDDEGREE  
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒22c. DATE SIGNED  
10/17/8722d. PHYSICIAN'S NAME (TYPE OR PRINT)  
KANG SUN LEE (Kang Sun Lee)22e. ADDRESS  
100 N Broadway23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY) Burial23b. DATE  
10-20-8723c. NAME OF CEMETERY OR CREMATORY  
Parkwood23d. LOCATION  
CITY OR TOWN COUNTY STATE  
Parkville, Balto. Co., Md.24. FUNERAL DIRECTOR  
NAME

Charles S. Zeiler &amp; Son Inc. 901 S. Conkling St.

ADDRESS

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

OCT 19 1987

Frederick R. Rode

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please affix carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked of item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BARBARA A. DUDLEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCT. 25, 1987</b>		2b. HOUR <b>11:57AM</b>	
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 12 1937</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Technician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Electronics</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Dudley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Robinson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
16b. SOCIAL SECURITY NO. <b>154-28-9247</b>		17. INFORMANT ADDRESS <b>Maryland 20770</b> <b>Daniel Dudley 6013 Springhill Drive, Greenbelt</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A systole</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive Brain infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic leiomyosarcoma</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u> <u>36 hours</u> <u>2 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION <b>10/22</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> , 19 <u>87</u> , to <u>10/25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>M E C BARRY</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/25/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M E C BARRY</b>		22e. ADDRESS <b>800 S. WOLFE ST BALTO, MD. 21205</b> <b>Johns Hopkins Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>10-27-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Baltimore Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Marzullo Funeral Service</b>				25a. DATE RECEIVED BY REGISTRAR <b>OCT 28 1987</b>		25b. REGISTRAR'S SIGNATURE

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OFFICE OF THE  
ATTORNEY GENERAL  
STATE OF NEW YORK  
100-100000-100

*[Faint, mostly illegible handwritten text, possibly a letter or memorandum, covering the majority of the page.]*

069701 OCT 26 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

37 28611

1. DECEASED NAME (TYPE OR PRINT) EDWARD NM1 DULICK			2a. DATE OF DEATH MONTH DAY YEAR 10-21-87			2b. HOUR 820 AM					
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 9-6-1917		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC.		12b. KIND OF BUSINESS OR INDUSTRY MACK TRUCK			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PA			13b. COUNTY —		13c. CITY OR TOWN GREEN CASTLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14173 WILLIAMSPORT PIKE, 17225		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN — DULICK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY — UNKNOWN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No —				16b. SOCIAL SECURITY NO. 145-12-0895	
17. INFORMANT ADDRESS 17225			LILLIAN DULICK			14173 WILLIAMSPORT PIKE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 minutes		
DUE TO, OR AS A CONSEQUENCE OF (b) arrhythmia									45 minutes		
DUE TO, OR AS A CONSEQUENCE OF (c) Secondary to myocardial infarction											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —			21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — —					
22a. I certify that (I) (this hospital) attended the deceased from 10/20, 1987, to 10/21, 1987, that (I) (we) last saw the deceased alive on 10/21, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Kathleen A. Devine MD						DEGREE MD			22c. DATE SIGNED 10-21-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHLEEN A. DEVINE						22e. ADDRESS UMH, DEPT of Medicine 22 S. Green Street BALT, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/24/87		23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH'S CHURCH + CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE BERRINEVILLE N.J.			
24. FUNERAL DIRECTOR NAME LILLY + ZEILER, INC.			ADDRESS 21231 1901 EASTERN AVE.			25a. DATE REC'D. BY REGISTRAR OCT 23 1987		25b. REGISTRAR'S SIGNATURE Julia Denden-Rodden			

UNITED STATES

DEPARTMENT OF THE ARMY

HEADQUARTERS

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28612

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST EMILY F. DUNDON			MONTH DAY YEAR 10/27/87			7:15 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE			7. IF UNDER 1 YEAR		
F	W	MONTH DAY YEAR Jan. 6, 1920	67 YRS			IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
Md.			USA			9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore City			BALTIMORE			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
BALTIMORE CITY			UNION MEMORIAL HOSPITAL			Secretary		
12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS / ZIP CODE			13b. CITY OR TOWN		
Medical			31 Parliament Ct. 21212			Baltimore		
13c. STATE			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
Md.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			31 Parliament Ct. 21212		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
FIRST MIDDLE LAST Harry Whayland			FIRST MIDDLE LAST Elizabeth Webster			(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
No			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
			217 10 2449			Mr. Bernard H. Dundon 825 Lenton Ave. -12		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small cell lung CA</u>			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <u>Small cell lung CA</u>			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> , 19 <u>87</u> , to <u>10/27</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Patrice W. Miller M.D.</u>				DEGREE		22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		10/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
PATRICE W. MILLER M.D.				UNION MEMORIAL HOSPITAL			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		10/29/87		Green Mount Cemetery		Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.				OCT 29 1987 <u>John Frederick Landwehr</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified directly.)

BP

Isabelle

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regional distribution.



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Item 18, 20, 21a, b, c, d, e, f, 22a, 22b, 22c, 22d, 22e, f, 22f, 22g, 22h, 22i, 22j, 22k, 22l, 22m, 22n, 22o, 22p, 22q, 22r, 22s, 22t, 22u, 22v, 22w, 22x, 22y, 22z, 23a, 23b, 23c, 23d, 23e, 23f, 23g, 23h, 23i, 23j, 23k, 23l, 23m, 23n, 23o, 23p, 23q, 23r, 23s, 23t, 23u, 23v, 23w, 23x, 23y, 23z, 24a, 24b, 24c, 24d, 24e, 24f, 24g, 24h, 24i, 24j, 24k, 24l, 24m, 24n, 24o, 24p, 24q, 24r, 24s, 24t, 24u, 24v, 24w, 24x, 24y, 24z, 25a, 25b, 25c, 25d, 25e, 25f, 25g, 25h, 25i, 25j, 25k, 25l, 25m, 25n, 25o, 25p, 25q, 25r, 25s, 25t, 25u, 25v, 25w, 25x, 25y, 25z, 26a, 26b, 26c, 26d, 26e, 26f, 26g, 26h, 26i, 26j, 26k, 26l, 26m, 26n, 26o, 26p, 26q, 26r, 26s, 26t, 26u, 26v, 26w, 26x, 26y, 26z, 27a, 27b, 27c, 27d, 27e, 27f, 27g, 27h, 27i, 27j, 27k, 27l, 27m, 27n, 27o, 27p, 27q, 27r, 27s, 27t, 27u, 27v, 27w, 27x, 27y, 27z, 28a, 28b, 28c, 28d, 28e, 28f, 28g, 28h, 28i, 28j, 28k, 28l, 28m, 28n, 28o, 28p, 28q, 28r, 28s, 28t, 28u, 28v, 28w, 28x, 28y, 28z, 29a, 29b, 29c, 29d, 29e, 29f, 29g, 29h, 29i, 29j, 29k, 29l, 29m, 29n, 29o, 29p, 29q, 29r, 29s, 29t, 29u, 29v, 29w, 29x, 29y, 29z, 30a, 30b, 30c, 30d, 30e, 30f, 30g, 30h, 30i, 30j, 30k, 30l, 30m, 30n, 30o, 30p, 30q, 30r, 30s, 30t, 30u, 30v, 30w, 30x, 30y, 30z, 31a, 31b, 31c, 31d, 31e, 31f, 31g, 31h, 31i, 31j, 31k, 31l, 31m, 31n, 31o, 31p, 31q, 31r, 31s, 31t, 31u, 31v, 31w, 31x, 31y, 31z, 32a, 32b, 32c, 32d, 32e, 32f, 32g, 32h, 32i, 32j, 32k, 32l, 32m, 32n, 32o, 32p, 32q, 32r, 32s, 32t, 32u, 32v, 32w, 32x, 32y, 32z, 33a, 33b, 33c, 33d, 33e, 33f, 33g, 33h, 33i, 33j, 33k, 33l, 33m, 33n, 33o, 33p, 33q, 33r, 33s, 33t, 33u, 33v, 33w, 33x, 33y, 33z, 34a, 34b, 34c, 34d, 34e, 34f, 34g, 34h, 34i, 34j, 34k, 34l, 34m, 34n, 34o, 34p, 34q, 34r, 34s, 34t, 34u, 34v, 34w, 34x, 34y, 34z, 35a, 35b, 35c, 35d, 35e, 35f, 35g, 35h, 35i, 35j, 35k, 35l, 35m, 35n, 35o, 35p, 35q, 35r, 35s, 35t, 35u, 35v, 35w, 35x, 35y, 35z, 36a, 36b, 36c, 36d, 36e, 36f, 36g, 36h, 36i, 36j, 36k, 36l, 36m, 36n, 36o, 36p, 36q, 36r, 36s, 36t, 36u, 36v, 36w, 36x, 36y, 36z, 37a, 37b, 37c, 37d, 37e, 37f, 37g, 37h, 37i, 37j, 37k, 37l, 37m, 37n, 37o, 37p, 37q, 37r, 37s, 37t, 37u, 37v, 37w, 37x, 37y, 37z, 38a, 38b, 38c, 38d, 38e, 38f, 38g, 38h, 38i, 38j, 38k, 38l, 38m, 38n, 38o, 38p, 38q, 38r, 38s, 38t, 38u, 38v, 38w, 38x, 38y, 38z, 39a, 39b, 39c, 39d, 39e, 39f, 39g, 39h, 39i, 39j, 39k, 39l, 39m, 39n, 39o, 39p, 39q, 39r, 39s, 39t, 39u, 39v, 39w, 39x, 39y, 39z, 40a, 40b, 40c, 40d, 40e, 40f, 40g, 40h, 40i, 40j, 40k, 40l, 40m, 40n, 40o, 40p, 40q, 40r, 40s, 40t, 40u, 40v, 40w, 40x, 40y, 40z, 41a, 41b, 41c, 41d, 41e, 41f, 41g, 41h, 41i, 41j, 41k, 41l, 41m, 41n, 41o, 41p, 41q, 41r, 41s, 41t, 41u, 41v, 41w, 41x, 41y, 41z, 42a, 42b, 42c, 42d, 42e, 42f, 42g, 42h, 42i, 42j, 42k, 42l, 42m, 42n, 42o, 42p, 42q, 42r, 42s, 42t, 42u, 42v, 42w, 42x, 42y, 42z, 43a, 43b, 43c, 43d, 43e, 43f, 43g, 43h, 43i, 43j, 43k, 43l, 43m, 43n, 43o, 43p, 43q, 43r, 43s, 43t, 43u, 43v, 43w, 43x, 43y, 43z, 44a, 44b, 44c, 44d, 44e, 44f, 44g, 44h, 44i, 44j, 44k, 44l, 44m, 44n, 44o, 44p, 44q, 44r, 44s, 44t, 44u, 44v, 44w, 44x, 44y, 44z, 45a, 45b, 45c, 45d, 45e, 45f, 45g, 45h, 45i, 45j, 45k, 45l, 45m, 45n, 45o, 45p, 45q, 45r, 45s, 45t, 45u, 45v, 45w, 45x, 45y, 45z, 46a, 46b, 46c, 46d, 46e, 46f, 46g, 46h, 46i, 46j, 46k, 46l, 46m, 46n, 46o, 46p, 46q, 46r, 46s, 46t, 46u, 46v, 46w, 46x, 46y, 46z, 47a, 47b, 47c, 47d, 47e, 47f, 47g, 47h, 47i, 47j, 47k, 47l, 47m, 47n, 47o, 47p, 47q, 47r, 47s, 47t, 47u, 47v, 47w, 47x, 47y, 47z, 48a, 48b, 48c, 48d, 48e, 48f, 48g, 48h, 48i, 48j, 48k, 48l, 48m, 48n, 48o, 48p, 48q, 48r, 48s, 48t, 48u, 48v, 48w, 48x, 48y, 48z, 49a, 49b, 49c, 49d, 49e, 49f, 49g, 49h, 49i, 49j, 49k, 49l, 49m, 49n, 49o, 49p, 49q, 49r, 49s, 49t, 49u, 49v, 49w, 49x, 49y, 49z, 50a, 50b, 50c, 50d, 50e, 50f, 50g, 50h, 50i, 50j, 50k, 50l, 50m, 50n, 50o, 50p, 50q, 50r, 50s, 50t, 50u, 50v, 50w, 50x, 50y, 50z, 51a, 51b, 51c, 51d, 51e, 51f, 51g, 51h, 51i, 51j, 51k, 51l, 51m, 51n, 51o, 51p, 51q, 51r, 51s, 51t, 51u, 51v, 51w, 51x, 51y, 51z, 52a, 52b, 52c, 52d, 52e, 52f, 52g, 52h, 52i, 52j, 52k, 52l, 52m, 52n, 52o, 52p, 52q, 52r, 52s, 52t, 52u, 52v, 52w, 52x, 52y, 52z, 53a, 53b, 53c, 53d, 53e, 53f, 53g, 53h, 53i, 53j, 53k, 53l, 53m, 53n, 53o, 53p, 53q, 53r, 53s, 53t, 53u, 53v, 53w, 53x, 53y, 53z, 54a, 54b, 54c, 54d, 54e, 54f, 54g, 54h, 54i, 54j, 54k, 54l, 54m, 54n, 54o, 54p, 54q, 54r, 54s, 54t, 54u, 54v, 54w, 54x, 54y, 54z, 55a, 55b, 55c, 55d, 55e, 55f, 55g, 55h, 55i, 55j, 55k, 55l, 55m, 55n, 55o, 55p, 55q, 55r, 55s, 55t, 55u, 55v, 55w, 55x, 55y, 55z, 56a, 56b, 56c, 56d, 56e, 56f, 56g, 56h, 56i, 56j, 56k, 56l, 56m, 56n, 56o, 56p, 56q, 56r, 56s, 56t, 56u, 56v, 56w, 56x, 56y, 56z, 57a, 57b, 57c, 57d, 57e, 57f, 57g, 57h, 57i, 57j, 57k, 57l, 57m, 57n, 57o, 57p, 57q, 57r, 57s, 57t, 57u, 57v, 57w, 57x, 57y, 57z, 58a, 58b, 58c, 58d, 58e, 58f, 58g, 58h, 58i, 58j, 58k, 58l, 58m, 58n, 58o, 58p, 58q, 58r, 58s, 58t, 58u, 58v, 58w, 58x, 58y, 58z, 59a, 59b, 59c, 59d, 59e, 59f, 59g, 59h, 59i, 59j, 59k, 59l, 59m, 59n, 59o, 59p, 59q, 59r, 59s, 59t, 59u, 59v, 59w, 59x, 59y, 59z, 60a, 60b, 60c, 60d, 60e, 60f, 60g, 60h, 60i, 60j, 60k, 60l, 60m, 60n, 60o, 60p, 60q, 60r, 60s, 60t, 60u, 60v, 60w, 60x, 60y, 60z, 61a, 61b, 61c, 61d, 61e, 61f, 61g, 61h, 61i, 61j, 61k, 61l, 61m, 61n, 61o, 61p, 61q, 61r, 61s, 61t, 61u, 61v, 61w, 61x, 61y, 61z, 62a, 62b, 62c, 62d, 62e, 62f, 62g, 62h, 62i, 62j, 62k, 62l, 62m, 62n, 62o, 62p, 62q, 62r, 62s, 62t, 62u, 62v, 62w, 62x, 62y, 62z, 63a, 63b, 63c, 63d, 63e, 63f, 63g, 63h, 63i, 63j, 63k, 63l, 63m, 63n, 63o, 63p, 63q, 63r, 63s, 63t, 63u, 63v, 63w, 63x, 63y, 63z, 64a, 64b, 64c, 64d, 64e, 64f, 64g, 64h, 64i, 64j, 64k, 64l, 64m, 64n, 64o, 64p, 64q, 64r, 64s, 64t, 64u, 64v, 64w, 64x, 64y, 64z, 65a, 65b, 65c, 65d, 65e, 65f, 65g, 65h, 65i, 65j, 65k, 65l, 65m, 65n, 65o, 65p, 65q, 65r, 65s, 65t, 65u, 65v, 65w, 65x, 65y, 65z, 66a, 66b, 66c, 66d, 66e, 66f, 66g, 66h, 66i, 66j, 66k, 66l, 66m, 66n, 66o, 66p, 66q, 66r, 66s, 66t, 66u, 66v, 66w, 66x, 66y, 66z, 67a, 67b, 67c, 67d, 67e, 67f, 67g, 67h, 67i, 67j, 67k, 67l, 67m, 67n, 67o, 67p, 67q, 67r, 67s, 67t, 67u, 67v, 67w, 67x, 67y, 67z, 68a, 68b, 68c, 68d, 68e, 68f, 68g, 68h, 68i, 68j, 68k, 68l, 68m, 68n, 68o, 68p, 68q, 68r, 68s, 68t, 68u, 68v, 68w, 68x, 68y, 68z, 69a, 69b, 69c, 69d, 69e, 69f, 69g, 69h, 69i, 69j, 69k, 69l, 69m, 69n, 69o, 69p, 69q, 69r, 69s, 69t, 69u, 69v, 69w, 69x, 69y, 69z, 70a, 70b, 70c, 70d, 70e, 70f, 70g, 70h, 70i, 70j, 70k, 70l, 70m, 70n, 70o, 70p, 70q, 70r, 70s, 70t, 70u, 70v, 70w, 70x, 70y, 70z, 71a, 71b, 71c, 71d, 71e, 71f, 71g, 71h, 71i, 71j, 71k, 71l, 71m, 71n, 71o, 71p, 71q, 71r, 71s, 71t, 71u, 71v, 71w, 71x, 71y, 71z, 72a, 72b, 72c, 72d, 72e, 72f, 72g, 72h, 72i, 72j, 72k, 72l, 72m, 72n, 72o, 72p, 72q, 72r, 72s, 72t, 72u, 72v, 72w, 72x, 72y, 72z, 73a, 73b, 73c, 73d, 73e, 73f, 73g, 73h, 73i, 73j, 73k, 73l, 73m, 73n, 73o, 73p, 73q, 73r, 73s, 73t, 73u, 73v, 73w, 73x, 73y, 73z, 74a, 74b, 74c, 74d, 74e, 74f, 74g, 74h, 74i, 74j, 74k, 74l, 74m, 74n, 74o, 74p, 74q, 74r, 74s, 74t, 74u, 74v, 74w, 74x, 74y, 74z, 75a, 75b, 75c, 75d, 75e, 75f, 75g, 75h, 75i, 75j, 75k, 75l, 75m, 75n, 75o, 75p, 75q, 75r, 75s, 75t, 75u, 75v, 75w, 75x, 75y, 75z, 76a, 76b, 76c, 76d, 76e, 76f, 76g, 76h, 76i, 76j, 76k, 76l, 76m, 76n, 76o, 76p, 76q, 76r, 76s, 76t, 76u, 76v, 76w, 76x, 76y, 76z, 77a, 77b, 77c, 77d, 77e, 77f, 77g, 77h, 77i, 77j, 77k, 77l, 77m, 77n, 77o, 77p, 77q, 77r, 77s, 77t, 77u, 77v, 77w, 77x, 77y, 77z, 78a, 78b, 78c, 78d, 78e, 78f, 78g, 78h, 78i, 78j, 78k, 78l, 78m, 78n, 78o, 78p, 78q, 78r, 78s, 78t, 78u, 78v, 78w, 78x, 78y, 78z, 79a, 79b, 79c, 79d, 79e, 79f, 79g, 79h, 79i, 79j, 79k, 79l, 79m, 79n, 79o, 79p, 79q, 79r, 79s, 79t, 79u, 79v, 79w, 79x, 79y, 79z, 80a, 80b, 80c, 80d, 80e, 80f, 80g, 80h, 80i, 80j, 80k, 80l, 80m, 80n, 80o, 80p, 80q, 80r, 80s, 80t, 80u, 80v, 80w, 80x, 80y, 80z, 81a, 81b, 81c, 81d, 81e, 81f, 81g, 81h, 81i, 81j, 81k, 81l, 81m, 81n, 81o, 81p, 81q, 81r, 81s, 81t, 81u, 81v, 81w, 81x, 81y, 81z, 82a, 82b, 82c, 82d, 82e, 82f, 82g, 82h, 82i, 82j, 82k, 82l, 82m, 82n, 82o, 82p, 82q, 82r, 82s, 82t, 82u, 82v, 82w, 82x, 82y, 82z, 83a, 83b, 83c, 83d, 83e, 83f, 83g, 83h, 83i, 83j, 83k, 83l, 83m, 83n, 83o, 83p, 83q, 83r, 83s, 83t, 83u, 83v, 83w, 83x, 83y, 83z, 84a, 84b, 84c, 84d, 84e, 84f, 84g, 84h, 84i, 84j, 84k, 84l, 84m, 84n, 84o, 84p, 84q, 84r, 84s, 84t, 84u, 84v, 84w, 84x, 84y, 84z, 85a, 85b, 85c, 85d, 85e, 85f, 85g, 85h, 85i, 85j, 85k, 85l, 85m, 85n, 85o, 85p, 85q, 85r, 85s, 85t, 85u, 85v, 85w, 85x, 85y, 85z, 86a, 86b, 86c, 86d, 86e, 86f, 86g, 86h, 86i, 86j, 86k, 86l, 86m, 86n, 86o, 86p, 86q, 86r, 86s, 86t, 86u, 86v, 86w, 86x, 86y, 86z, 87a, 87b, 87c, 87d, 87e, 87f, 87g, 87h, 87i, 87j, 87k, 87l, 87m, 87n, 87o, 87p, 87q, 87r, 87s, 87t, 87u, 87v, 87w, 87x, 87y, 87z, 88a, 88b, 88c, 88d, 88e, 88f, 88g, 88h, 88i, 88j, 88k, 88l, 88m, 88n, 88o, 88p, 88q, 88r, 88s, 88t, 88u, 88v, 88w, 88x, 88y, 88z, 89a, 89b, 89c, 89d, 89e, 89f, 89g, 89h, 89i, 89j, 89k, 89l, 89m, 89n, 89o, 89p, 89q, 89r, 89s, 89t, 89u, 89v, 89w, 89x, 89y, 89z, 90a, 90b, 90c, 90d, 90e, 90f, 90g, 90h, 90i, 90j, 90k, 90l, 90m, 90n, 90o, 90p, 90q, 90r, 90s, 90t, 90u, 90v, 90w, 90x, 90y, 90z, 91a, 91b, 91c, 91d, 91e, 91f, 91g, 91h, 91i, 91j, 91k, 91l, 91m, 91n, 91o, 91p, 91q, 91r, 91s, 91t, 91u, 91v, 91w, 91x, 91y, 91z, 92a, 92b, 92c, 92d, 92e, 92f, 92g, 92h, 92i, 92j, 92k, 92l, 92m, 92n, 92o, 92p, 92q, 92r, 92s, 92t, 92u, 92v, 92w, 92x, 92y, 92z, 93a, 93b, 93c, 93d, 93e, 93f, 93g, 93h, 93i, 93j, 93k, 93l, 93m, 93n, 93o, 93p, 93q, 93r, 93s, 93t, 93u, 93v, 93w, 93x, 93y, 93z, 94a, 94b, 94c, 94d, 94e, 94f, 94g, 94h, 94i, 94j, 94k, 94l, 94m, 94n, 94o, 94p, 94q, 94r, 94s, 94t, 94u, 94v, 94w, 94x, 94y, 94z, 95a, 95b, 95c, 95d, 95e, 95f, 95g, 95h, 95i, 95j, 95k, 95l, 95m, 95n, 95o, 95p, 95q, 95r, 95s, 95t, 95u, 95v, 95w, 95x, 95y, 95z, 96a, 96b, 96c, 96d, 96e, 96f, 96g, 96h, 96i, 96j, 96k, 96l, 96m, 96n, 96o, 96p, 96q, 96r, 96s, 96t, 96u, 96v, 96w, 96x, 96y, 96z, 97a, 97b, 97c, 97d, 97e, 97f, 97g, 97h, 97i, 97j, 97k, 97l, 97m, 97n, 97o, 97p, 97q, 97r, 97s, 97t, 97u, 97v, 97w, 97x, 97y, 97z, 98a, 98b, 98c, 98d, 98e, 98f, 98g, 98h, 98i, 98j, 98k, 98l, 98m, 98n, 98o, 98p, 98q, 98r, 98s, 98t, 98u, 98v, 98w, 98x, 98y, 98z, 99a, 99b, 99c, 99d, 99e, 99f, 99g, 99h, 99i, 99j, 99k, 99l, 99m, 99n, 99o, 99p, 99q, 99r, 99s, 99t, 99u, 99v, 99w, 99x, 99y, 99z, 100a, 100b, 100c, 100d, 100e, 100f, 100g, 100h, 100i, 100j, 100k, 100l, 100m, 100n, 100o, 100p, 100q, 100r, 100s, 100t, 100u, 100v, 100w, 100x, 100y, 100z

FOR  
STATE  
REGISTRAR

10-27-87 per med exam

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28613

1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH			ESTIMATED			MONTH			DAY			YEAR			2b. HOUR					
Edna			Shore			Dunithan						10/2/87												8:35 P M								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			IF UNDER 1 YR.			IF UNDER 24 HRS.			7c. DATE PRONOUNCED DEAD			MONTH			DAY			YEAR			2d. HOUR		
F.			W			12/7/63			23 YRS.									10/2/87														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			WIDOWED			DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH														
Baltimore																		Baltimore City,									MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																							
Baltimore			836 Herndon Court			Homemaker																										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS																				
Md.						Baltimore			YES			836 Herndon Court																				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																													
Charles Dunithan			Hatsour																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS																							
No			916-724921			James Curren			836 Herndon Court																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF																							



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20% COTTON EMB

CHIEF-AMM

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Elsie Dunlap</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 26, 1987</b>		2b. HOUR <b>3:30 P.M.</b>
3 SEX <b>Female</b>	4 RACE <b>Black</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 09, 1921</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY
13a STATE <b>Maryland</b>			13b COUNTY	13c CITY OR TOWN <b>Baltimore</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Nathan White</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Drusilla Carpenter</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>-</b>		17 INFORMANT ADDRESS <b>Elizabeth Phillip Box 40A Lusby, MD 20567</b>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Lung Carcinoma, Possibly Metastatic**

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**4 Days**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 22, 1987</b> , to <b>October 26, 1987</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 26, 1987</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.			
22b. SIGNATURE <b>Karl F. Love, MD</b>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/26/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Karl F. Love, MD</b>	22e. ADDRESS <b>c/o Maryland General Hospital</b>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Oct. 30, 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Church Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lusby Calvert MD</b>
24 FUNERAL DIRECTOR NAME <b>Spencer E. Sewell</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1987</b>	25b. REGISTRAR'S SIGNATURE <b>Davidson Landell</b>



068536 OCT

487 FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DENNIS J DUNN			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 6, 1987		2b. HOUR 10:49 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 6 54		6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Edgewood	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 836 Williamsburg Ct. 21040
14. FATHER'S NAME FIRST MIDDLE LAST James Corbett Dunn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lonis Love Hankla		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Daniel W. Dunn, 835 Kingston Court, Edgewood, Md. 21040	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pericardial Tamponade</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 day</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION <u>10/2/87</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Aortic insufficiency</u>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/2</u> , 19 <u>87</u> , to <u>10/6</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Lee H. Riley, III, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10/6/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lee H. Riley, III, M.D.</u>		22e. ADDRESS THE JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/9/87	23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Md.	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399		25a. DATE REC'D. BY REGISTRAR OCT 13 1987		25b. REGISTRAR'S SIGNATURE <u>J. H. Darden</u>	

MEDICAL CERTIFICATION

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. The permit must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of cause.

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69085 OCT 20 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28010

REG. NO.

1- FOR  
STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

WENDELL

WHITE

DURST

2a. DATE KNOWN OF DEATH  
ESTIMATED  
MONTH DAY YEAR  
10 7 1987  
2b. HOUR  
04003. SEX  
Male4. RACE  
White5. DATE OF BIRTH  
MONTH DAY YEAR  
April 27, 19206. AGE (IN YEARS)  
LAST BIRTHDAY  
67 YRS.IF UNDER 1 YR.  
MONTHS DAYSIF UNDER 24 HRS.  
HOURS MIN.2c. DATE PRONOUNCED DEAD  
MONTH DAY YEAR  
10 7 1987  
2d. HOUR  
08107a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Maryland7b. CITIZEN OF WHAT COUNTRY?  
USA8. MARRIED  
WIDOWED ☐ NEVER MARRIED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH  
Baltimore City MD10. CITY OR TOWN OF DEATH  
Dundalk11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
1013 Dulton Avenue12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Painter12b. KIND OF BUSINESS OR INDUSTRY  
House Paint.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Md.13b. COUNTY  
Garrett13c. CITY OR TOWN  
Mt. Lake Park13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐13e. STREET ADDRESS  
705 N St., Apt. 4 2155014. FATHER'S NAME  
FIRST MIDDLE LAST  
Charles R. Durst15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST  
Myrtle ----- Fitzwater16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)  
Yes16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)  
WW II 705-12-129717. INFORMANT  
ADDRESS  
Catherine E. Durst, See #13 above18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a)  
DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

Cancer of the lung with multiple metastases

(b)  
DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 month

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?  
YES ☐ NO ☒21a. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion

ACTUAL SIGNATURE J. Rossan O'Donovan

DATE SIGNED 10/7/87

EXAMINER'S NAME (TYPE OR PRINT) J. ROSSAN O'DONOVAN

M.D. Deputy MEDICAL EXAMINER ADDRESS 2112 DUNDALK AVE., BALTO., MD. 21222

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Cremation23b. DATE  
10/9/8723c. NAME OF CEMETERY OR CREMATORY  
Omega Crematory23d. LOCATION  
CITY OR TOWN COUNTY STATE  
Morgantown, Monongalia, WV24. FUNERAL DIRECTOR  
NAME ADDRESS  
Bradley A. Stewart Oakland, Maryland 2155025a. DATE REC'D. BY REGISTRAR  
OCT 19 1987  
25b. REGISTRAR'S SIGNATURE  
Julia Denton-Rudell

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28017

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DRESSIE MURRAY DYSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 4, 1987</b>		2b. HOUR <b>11:46P M</b>						
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 7 1932</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>55</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>FLORIDA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>—</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>						13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MACK CARLTON MURRAY</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DRESSIE O'NEIL STEPHEN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO.</b>		16b. SOCIAL SECURITY NO. <b>220-24-1806</b>		17. INFORMANT <b>MR. BERNETT A. DYSON</b>		18. ADDRESS <b>BALTIMORE, MD. 3011 PIEDMONT AVE.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>metastatic brain lesion</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>non small cell lung carcinoma</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-3 months</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>none</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <b>18 Sept 87</b> to <b>4 Oct 87</b> ; that (2) I saw the deceased alive on <b>4 Oct 87</b> ; and that in my opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)											
22b. SIGNATURE <b>BEN. YOKEL MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/4/87</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BEN. YOKEL MD</b>		22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL 600 N WOLFE ST BALTO MD 21205</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>ENTOMBMENT</b>		23b. DATE <b>10/9/1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MD.</b>					
24. FUNERAL HOME <b>NUSTER FUNERAL HOMES, INC.</b> ADDRESS <b>2501 GWYNNS FALLS PKWY. BALTO. MD. 21216</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 07 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Deaton Rader</b>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (This permit is required for the removal of the body to the funeral home or to the cemetery.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



7

1. The first part of the report is a description of the project. It is a study of the effects of the new law on the economy. The study was conducted by a group of experts in the field. They found that the new law had a significant impact on the economy. It caused a decrease in the number of jobs and a decrease in the amount of money that was being spent. This was a very serious problem for the country. The government was forced to take action to deal with the problem. They passed a new law that would help to restore the economy. This law was very important for the country. It helped to bring the economy back to its former state. The new law was a great success. It showed that the government was able to deal with the problem. It was a very important step in the history of the country. The new law was a great success. It showed that the government was able to deal with the problem. It was a very important step in the history of the country.

2. The second part of the report is a description of the results of the study. The study found that the new law had a significant impact on the economy. It caused a decrease in the number of jobs and a decrease in the amount of money that was being spent. This was a very serious problem for the country. The government was forced to take action to deal with the problem. They passed a new law that would help to restore the economy. This law was very important for the country. It helped to bring the economy back to its former state. The new law was a great success. It showed that the government was able to deal with the problem. It was a very important step in the history of the country.

3. The third part of the report is a description of the conclusions of the study. The study found that the new law had a significant impact on the economy. It caused a decrease in the number of jobs and a decrease in the amount of money that was being spent. This was a very serious problem for the country. The government was forced to take action to deal with the problem. They passed a new law that would help to restore the economy. This law was very important for the country. It helped to bring the economy back to its former state. The new law was a great success. It showed that the government was able to deal with the problem. It was a very important step in the history of the country.